Application
(Original)

DeLozier Surgery Center

CN1711-032

State of Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution

DeLozier Surgery Center

Name

209 23rd Avenue North — Davidson

Street or Route — County

Nashville — TN — 37203

City — State — Zip Code

Website address: _____

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

2. Contact Person Available for Responses to Questions

Brian White

Name — Title

Competitive Solutions, LLC — info@competitivesolutions.com

Company Name — Email address

720 Cool Springs Blvd. Suite 470 — Franklin — TN — 37067

Street or Route — City — State — Zip Code

Consultant — 615.369.6336 x11 — 615.369.6336

Association with Owner — Phone Number — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable).* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;
2) Ownership structure;
3) Service area;
4) Existing similar service providers;
5) Project cost;
6) Funding;
7) Financial Feasibility including when the proposal will realize a positive financial margin; and
8) Staffing.

DeLozier Surgery Center intends to convert the current single specialty plastic surgery ASTC with 1 operating room to a multi-specialty ASTC with no increase in the bed complement. The ownership structure will remain the same with DeLozier Surgery Center, LLC owning 100% of the ASTC and controlled by its sole member, Dr. Joseph B. DeLozier, III, MD.

The ASTC will continue to service Davidson and Williamson counties with approximately 85% of the centers business derived from those two counties. No other county accounts for more than 5% of the projected case volume. The additional specialties served by the ASTC will be pain management and podiatry.

The market is currently served by 9 multi-specialty ASTCs open to all market providers and 2 ASTCs dedicated to pain management limited to the owner practices. The multi-specialty ASTCs currently restrict access to pain management and podiatry in favor of more profitable lines of service including orthopedic surgery, ophthalmology and GI. Plastic surgery, pain management and podiatry have seen significant reductions in case volume in the existing centers over the past three years.

The Project Cost is estimated to be $50,000 and will be funded by the current owners of the center from operating income and cash reserves. Because the plan will not expand the physical plant of the ASTC, the project requires very little investment and is financially feasible as it will increase the revenue of the ASTC with little to no fixed cost associated with the expansion.

The ASTC's new services will be staffed with pain management physicians and podiatrists currently working in the market and current ancillary staff will expand their work hours to accommodate the new volume. Some PRN additional labor may be required and the ASTC currently has a pool of ancillary staff that works on an as needed basis.

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B. of this application. Please summarize in one page or less each of the criteria:

1) Need;

Currently the corporate partnership model surgery centers are squeezing out pain management and podiatry for higher revenue procedures in orthopedics, ophthalmology and neurosurgery. The existing pain management centers are owned by specific pain management service providers and not reasonably accessible to providers not employed by those groups. The expansion will provide greater access to patients, expand the available options for surgical treatment of pain management and podiatry patients.

2) Economic Feasibility;

The addition of these services will require minimal investment in equipment, reducing the cost of entry. The expansion of services will allow DeLozier Surgery Center to expand the use of existing infrastructure generating greater access for patients and immediate revenue expansion at limited increase in fixed cost.

3) Appropriate Quality Standards; and

DeLozier Surgery Center currently participates in Medicare certification programs as well as AAAASF accreditation programs and will expand those quality programs to the new service lines offered.

4) Orderly Development to adequate and effective health care.

This conversion to multi-specialty ASTC from single specialty ASTC designation will not change the overall bed compliment in the market, will improve access to care for pain management and podiatry patients in a ASTC that is already fully credentialed and compliant with local, state

and federal regulations. The ASTC will serve patients across all demographic groups in Davidson and Williamson counties.

C. Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

4. SECTION A: PROJECT DETAILS

A. Owner of the Facility, Agency or Institution

DeLozier Surgery Center, LLC		615.565.9000
Name		Phone Number
209 23rd Avenue North		Davidson
Street or Route		County
Nashville	TN	37203
City	State	Zip Code

B. Type of Ownership of Control (Check One)

A.	Sole Proprietorship _____	F.	Government (State of TN or _____ Political Subdivision)
B.	Partnership _____		
C.	Limited Partnership _____	G.	Joint Venture _____
D.	Corporation (For Profit) _____	H.	Limited Liability Company ___X___
E.	Corporation (Not-for-Profit) _____	I.	Other (Specify)_____ _____

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx. **Attachment Section A-4A.**

Describe *the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.*

5. Name of Management/Operating Entity (If Applicable)

Not Applicable
Name

Street or Route

County

City

State

Zip Code

Website address: _____

For new facilities or existing facilities *without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.* **Attachment Section A-5**.

6A. Legal Interest in the Site of the Institution (Check One)

A.	Ownership __X__	D. Option to Lease _____	
B.	Option to Purchase _____	E. Other (Specify) _____	_____
C.	Lease of _____ Years _____	_____	

Check appropriate line above: *For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

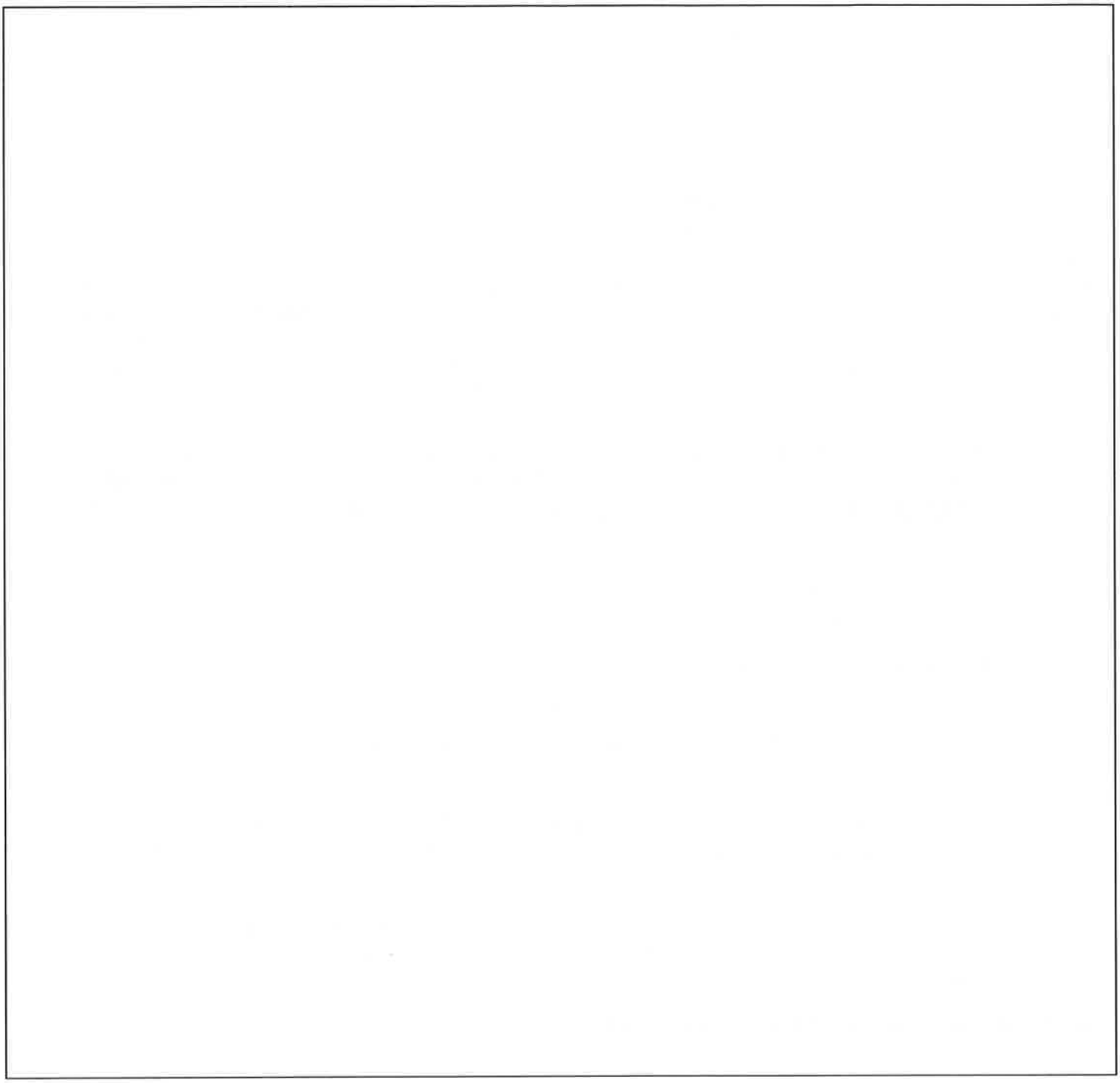
6B. Attach **a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site** on an 8 1/2" x 11" sheet of white paper, single or double-sided. ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

1) Plot Plan **must include**:
   a. Size of site (***in acres***);
   b. Location of structure on the site;
   c. Location of the proposed construction/renovation; and
   d. Names of streets, roads or highway that cross or border the site.

2) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8 ½ by 11 sheet of paper or as many as necessary to illustrate the floor plan.

3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Attachment Section A-6A, 6B-1 a-d, 6B-2, 6B-3.



7. Type of Institution (Check as appropriate--more than one response may apply)

A. Hospital (Specify)_____ _____
B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty __X__
C. ASTC, Single Specialty _____
D. Home Health Agency _____
E. Hospice _____
F. Mental Health Hospital _____
G. Intellectual Disability Institutional Habilitation Facility ICF/IID _____
H. Nursing Home _____
I. Outpatient Diagnostic Center _____
J. Rehabilitation Facility _____
K. Residential Hospice _____
L. Nonresidential Substitution-Based Treatment Center for Opiate Addiction _____
M. Other (Specify)_____ _____

Check appropriate lines(s).

8. Purpose of Review (Check appropriate lines(s) – more than one response may apply)

A. New Institution _____
B. Modifying an ASTC with limitation still required per CON __X__
C. Addition of MRI Unit _____
D. Pediatric MRI _____
E. Initiation of Health Care Service as defined in T.C.A. §68-11-1607(4) _____
(Specify)_____
F. Change in Bed Complement _____
[Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]
G. Satellite Emergency Dept. _____
H. Change of Location _____
I. Other (Specify)_____ _____

9. Medicaid/TennCare, Medicare Participation

MCO Contracts [Check all that apply]

___AmeriGroup ___United Healthcare Community Plan ___BlueCare ___TennCare Select

Medicare Provider Number ___3089369_____

Medicaid Provider Number _____

Certification Type _____

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare __Yes __No __N/A Medicaid/TennCare __Yes __No __N/A

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.

		Current Licensed	*Beds Staffed*	*Beds Proposed*	**Beds Approved*	***Beds Exempted*	*TOTAL Beds at Completion*
1)	Medical						
2)	Surgical	1	1	1			1
3)	ICU/CCU						
4)	Obstetrical						
5)	NICU						
6)	Pediatric						
7)	Adult Psychiatric						
8)	Geriatric Psychiatric						
9)	Child/Adolescent Psychiatric						
10)	Rehabilitation						
11)	Adult Chemical Dependency						
12)	Child/Adolescent Chemical Dependency						
13)	Long-Term Care Hospital						
14)	Swing Beds						
15)	Nursing Home – SNF (Medicare only)						
16)	Nursing Home – NF (Medicaid only)						
17)	Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18)	Nursing Home – Licensed (non-certified)						
19)	ICF/IID						
20)	Residential Hospice						
TOTAL		1	1	1			1

**Beds approved but not yet in service* ***Beds exempted under 10% per 3 year provision*

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. **Attachment Section A-10.**

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.

CON Number(s)	CON Expiration Date	Total Licensed Beds Approved

11. **Home Health Care Organizations** – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	☐	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	☐	McMinn	☐	☐	☐
Campbell	☐	☐	☐	McNairy	☐	☐	☐
Cannon	☐	☐	☐	Macon	☐	☐	☐
Carroll	☐	☐	☐	Madison	☐	☐	☐
Carter	☐	☐	☐	Marion	☐	☐	☐
Cheatham	☐	☐	☐	Marshall	☐	☐	☐
Chester	☐	☐	☐	Maury	☐	☐	☐
Claiborne	☐	☐	☐	Meigs	☐	☐	☐
Clay	☐	☐	☐	Monroe	☐	☐	☐
Cocke	☐	☐	☐	Montgomery	☐	☐	☐
Coffee	☐	☐	☐	Moore	☐	☐	☐
Crockett	☐	☐	☐	Morgan	☐	☐	☐
Cumberland	☐	☐	☐	Obion	☐	☐	☐
Davidson	✠	✠	✠	Overton	☐	☐	☐
Decatur	☐	☐	☐	Perry	☐	☐	☐
DeKalb	☐	☐	☐	Pickett	☐	☐	☐
Dickson	☐	☐	☐	Polk	☐	☐	☐
Dyer	☐	☐	☐	Putnam	☐	☐	☐
Fayette	☐	☐	☐	Rhea	☐	☐	☐
Fentress	☐	☐	☐	Roane	☐	☐	☐
Franklin	☐	☐	☐	Robertson	☐	☐	☐
Gibson	☐	☐	☐	Rutherford	☐	☐	☐
Giles	☐	☐	☐	Scott	☐	☐	☐
Grainger	☐	☐	☐	Sequatchie	☐	☐	☐
Greene	☐	☐	☐	Sevier	☐	☐	☐
Grundy	☐	☐	☐	Shelby	☐	☐	☐
Hamblen	☐	☐	☐	Smith	☐	☐	☐
Hamilton	☐	☐	☐	Stewart	☐	☐	☐
Hancock	☐	☐	☐	Sullivan	☐	☐	☐
Hardeman	☐	☐	☐	Sumner	☐	☐	☐
Hardin	☐	☐	☐	Tipton	☐	☐	☐
Hawkins	☐	☐	☐	Trousdale	☐	☐	☐
Haywood	☐	☐	☐	Unicoi	☐	☐	☐
Henderson	☐	☐	☐	Union	☐	☐	☐
Henry	☐	☐	☐	Van Buren	☐	☐	☐
Hickman	☐	☐	☐	Warren	☐	☐	☐
Houston	☐	☐	☐	Washington	☐	☐	☐
Humphreys	☐	☐	☐	Wayne	☐	☐	☐
Jackson	☐	☐	☐	Weakley	☐	☐	☐
Jefferson	☐	☐	☐	White	☐	☐	☐
Johnson	☐	☐	☐	Williamson	☐	☐	☐
Knox	☐	☐	☐	Wilson	☐	☐	☐

12. Square Footage and Cost Per Square Footage Chart

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
No Change							
Unit/Department GSF Sub-Total							
Other GSF Total							
Total GSF							
*Total Cost							
**Cost Per Square Foot							
Cost per Square Foot Is Within Which Range *(For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hsda)*					☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile

* The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.

13. MRI, PET, and/or Linear Accelerator *Not Applicable*

1. Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000 and/or
2. Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following: A. Complete the chart below for acquired equipment.

☐ Linear Accelerator	Mev _____ Types: ☐ SRS ☐ IMRT ☐ IGRT ☐ Other _____ ☐ By Purchase Total _____ Cost*: ☐ By Lease ____ Expected Useful Life (yrs) _____ ☐ New ☐ Refurbished ☐ If not new, how old? (yrs)
☐ MRI	☐ Breast ☐ Extremity Tesla: ____ Magnet: ☐ Open ☐ Short Bore ☐ Other _____ ☐ By Purchase Total _____ Cost*: ☐ By Lease Expected ____ Useful Life (yrs) _____ ☐ New ☐ Refurbished ☐ If not new, how old? (yrs)
☐ PET	☐ PET only ☐ PET/CT ☐ PET/MRI ☐ By Purchase Total Cost*: _____ ☐ By Lease Expected Useful Life (yrs) ____ ☐ New ☐ Refurbished ☐ If not new, how old? (yrs)

* As defined by Agency Rule 0720-9-.01(13)

B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

C. Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

D. Schedule of Operations:

Location	Days of Operation (*Sunday through Saturday*)	Hours of Operation (*example: 8 am – 3 pm*)
Fixed Site *(Applicant)*		
Mobile Locations *(Applicant)*		
(Name of Other Location)		
(Name of Other Location)		

E. Identify the clinical applications to be provided that apply to the project.

F. If the equipment has been approved by the FDA within the last five years provide documentation of the same.

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the State Health Plan developed pursuant to T.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper, single-sided or double sided*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. ***If a question does not apply to your project, indicate "Not Applicable (NA)."***

QUESTIONS SECTION

B: NEED

A. Provide a response to each criterion and standard in Certificate of Need Categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the Tennessee Health Services and Development Agency or found on the Agency's website at http://www.tn.gov/hsda/article/hsda-criteria-and-standards.

1. Need. The minimum numbers of 884 Cases per Operating Room and 1867 Cases per Procedure Room are to be considered as baseline numbers for purposes of determining Need. An applicant should demonstrate the ability to perform a minimum of 884 Cases per Operating Room and/or 1867 Cases per Procedure Room per year, except that an applicant may provide information on its projected case types and its assumptions of estimated average time and clean up and preparation time per Case if this information differs significantly from the above-stated assumptions. It is recognized that an ASTC may provide a variety of services/Cases and that as a result the estimated average time and clean up and preparation time for such services/Cases may not meet the minimum numbers set forth herein. It is also recognized that an applicant applying for an ASTC Operating Room(s) may apply for a Procedure Room, although the anticipated utilization of that Procedure Room may not meet the base guidelines contained here. Specific reasoning and explanation for the inclusion in a CON application of such a Procedure Room must be provided. An applicant that desires to limit its Cases to a specific type or types should apply for a Specialty ASTC.

The Operating Room will be available Monday thru Saturday, approximately 300 days per year, 8 hours per day. The average time per outpatient surgery will be 40 minutes, 10 minutes for patient preparation, 20 minutes for performance of the procedure, and 10 minutes for patient recovery. The average time for cleanup and preparation between cases will be 10 minutes. This will allow the ASTC to have an estimated capacity well in excess of the 884 case per year guideline.

The plastic surgery cases performed have a broad range of time required during the procedure, from 30 minutes to several hours. The addition of pain management and podiatry cases will reduce the average time per

outpatient surgery as the planned procedures will be short in duration – between 20 and 30 minutes per outpatient procedure.

2. Need and Economic Efficiencies. An applicant must estimate the projected surgical hours to be utilized per year for two years based on the types of surgeries to be performed, including the preparation time between surgeries. Detailed support for estimates must be provided.

The projected hours of utilization for the first 8 quarters is as follows:

Quarter	Projected Hours
2018 Q1	430
2018 Q2	430
2018 Q3	430
2018 Q4	430
Total Year 1	1,720
2019 Q1	430
2019 Q2	430
2019 Q3	430
2019 Q4	430
Total Year 2	1,720

The center is currently used Monday thru Friday from approximately 7AM to 1PM. Current cases include blepharoplasty, reduction mammoplasty, breast reconstruction, augmentation mammoplasty, rhinoplasty and rhytidectomy among others.
The additional services will be performed Monday thru Friday from approximately 2PM to 5PM and on Saturdays from 8AM to 5PM. Those procedures will include facet joint injections, facet joint denervation, epidural steroid injections, transforaminal epidural injections, selective nerve root blocks, plantar fasciotomy, bunion corrections, etc.

3. Need; Economic Efficiencies; Access. To determine current utilization and need, an applicant should take into account both the availability and utilization of either: a) all existing outpatient Operating Rooms and Procedure Rooms in a Service Area, including physician office based surgery rooms (when those data are officially reported and available3) OR b) all existing comparable outpatient Operating Rooms and Procedure Rooms based on the type of Cases to be performed. Additionally, applications should provide similar information on the availability of nearby out-of-state existing outpatient Operating Rooms and Procedure Rooms, if that data are available, and provide the source of that data. Unstaffed dedicated outpatient Operating Rooms and unstaffed dedicated outpatient Procedure Rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.

- *There are currently 46 Operating Rooms and 19 Procedure Rooms providing similar services in the market.*
- *In 2016 the current Operating Rooms averaged 1002 cases per year and Procedure Rooms averaged 1062 cases per year.*
- *However, the quantity of procedures in this project's target specialties decreased by the percentages below as availability of operating and procedure room time shifted to higher margin specialties:*
    - *Plastic Surgery down 64.03% from 2014 to 2016*
    - *Pain Management down 44% from 2014 to 2016*
    - *Podiatry down 74.79% from 2014 to 2016*
- *The corporate and joint venture ASTCs are at or near capacity.*
- *Population growth provides additional need. Tennessee Department of Health statistics indicate the two-county market has seen 9.96% population growth from 2010 to 2015.*
- *Lower revenue per procedure services like plastics, pain and podiatry are getting squeezed out by higher revenue procedures like orthopedics, ophthalmology and neurosurgery. Those higher revenue procedures are also seeing increases in the percentage of cases moving from inpatient to outpatient environments.*
- *This proposal does not increase the number of ASTC operating rooms in the market.*

4. Need and Economic Efficiencies. An applicant must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are known and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above.

- *2016 Joint Annual Reports indicate that the average ASTC operating room in the target market has 1,002 cases per year, above the 884 threshold.*
- *This proposed expansion of service will not increase the number of operating rooms in the market. This expansion will simply make better use of the existing operating room.*

5. Need and Economic Efficiencies. An application for a Specialty ASTC should present its projections for the total number of cases based on its own calculations for the projected length of time per type of case, and shall provide any local, regional, or national data in support of its methodology. An applicant for a Specialty ASTC should provide its own definitions of the surgeries and/or procedures that will be performed and whether the Surgical Cases will be performed in an Operating Room or a Procedure Room. An applicant for a Specialty ASTC must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON proposal to establish a Specialty ASTC or to expand existing services of a Specialty ASTC shall not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently

utilized at 70% or above. An applicant that is granted a CON for a Specialty ASTC shall have the specialty or limitation placed on the CON.

- *Expansion of services to include pain and podiatry is needed because the bulk of the volume in the target market is in two centers that are restricted to the center ownership.*
- *The multi-specialty centers have low volumes in podiatry and pain management.*
- *Our plan has physicians in these specialties who are currently restricted in the number of procedures they can perform due to limited availability in the existing multi-specialty centers.*

6. Access to ASTCs. An applicant should provide information regarding the relationship of an existing or proposed ASTC site to public transportation routes if that information is available.

- *Metro Davidson County bus lines have stops within a half mile of the 23rd Avenue location on Charlotte Avenue and Elliston Place.*

7. Access to ASTCs. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project the origin of potential patients by percentage and county of residence and, if such data are readily available, by zip code, and must note where they are currently being served. Demographics of the Service Area should be included, including the anticipated provision of services to out-of-state patients, as well as the identity of other service providers both in and out of state and the source of out-of-state data. Applicants shall document all other provider alternatives available in the Service Area. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

- *75% Davidson; 15% Williamson; Balance is broadly scattered from Cheatum, Sumner, Wilson and beyond.*
- *The Davidson/Williamson market has seen a significant drop in plastic surgery, pain management and podiatry services provided in the ASTC setting against a growing population. This project will improve access to those services to the market.*

8. Access and Economic Efficiencies. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following completion of the project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

The projected case volume for the first 8 quarters is as follows:

Quarter	*Projected Cases*
2018 Q1	*250*
2018 Q2	*250*
2018 Q3	*250*
2018 Q4	*250*
Total Year 1	*1000*
2019 Q1	*250*
2019 Q2	*250*
2019 Q3	*250*
2019 Q4	*250*
Total Year 2	*1000*

Dr. DeLozier has historically performed between 440 and 480 procedures per year as reported in his Joint Annual Reports. The addition of pain management and podiatry procedures is anticipated to increase the number of procedures performed by between 500 and 600 procedures annually, reaching a total of approximately 1000 procedures per year.
The additional pain management and podiatry services projected are based upon estimated current volume provided by physicians interested in using the operating room in its current setting.

9. Patient Safety and Quality of Care; Health Care Workforce.

a. An applicant should be or agree to become accredited by any accrediting organization approved by the Centers for Medicare and Medicaid Services, such as the Joint Commission, the Accreditation Association of Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgical Facilities, or other nationally recognized accrediting organization.

Center is currently accredited by American Association for Accreditation of Ambulatory Surgical Facilities.

b. An applicant should estimate the number of physicians by specialty that are expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel. An applicant should provide documentation on the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

Current plan is for 1 existing plastic surgeon; 1 pain management physician and 1 podiatrist. The center will use existing staff and fill hours as necessary with PRN nursing and techs readily identified and available in the market. The ASTC currently uses PRN labor to assist with patient care during seasonally busy times of year and has reasonable access to labor to accommodate the increased number of cases.

11. Access to ASTCs. In light of Rule 0720-11.01, which lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, "Every citizen should have reasonable access to health care," the HSDA may decide to give special consideration to an applicant:

a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;

Not Applicable

b. Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program;

Not Applicable

c. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program; or

DeLozier Surgery Center currently participates in Medicare.

d. Who is proposing to use the ASTC for patients that typically require longer preparation and scanning times. The applicant shall provide in its application information supporting the additional time required per Case and the impact on the need standard.

Not Applicable

B. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to related previously approved projects of the applicant.

Not Applicable

C. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable. **Attachment Section B - Need-C.**

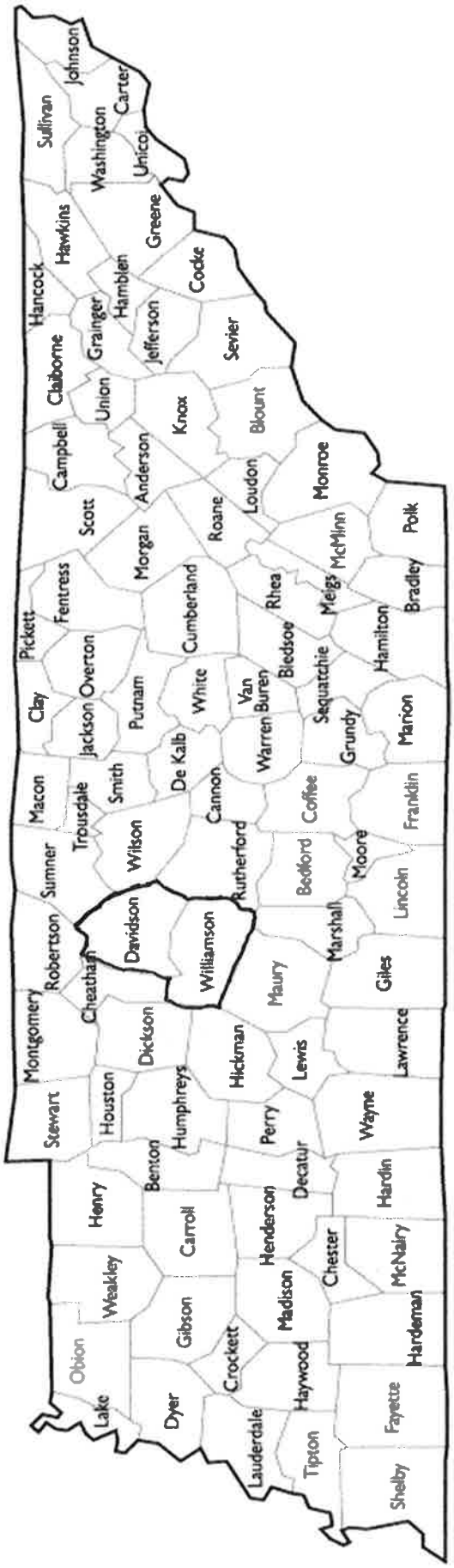
Please complete the following tables, if applicable:

Service Area Counties	Historical Utilization-County Residents	% of total procedures
County #1	Davidson	75%
County #2	Williamson	10%
Etc.		15%
Total		100%

Service Area Counties	Projected Utilization-County Residents	% of total procedures
County #1	Davidson	75%
County #2	Williamson	10%
Etc.		15%
Total		100%

- *We anticipate maintaining the current county of origination in our ASTC with the addition of the services proposed - 75% Davidson; 15% Williamson; Balance is broadly scattered from Cheatum, Sumner, Wilson and beyond.*
- *The Davidson/Williamson market has seen a significant drop in plastic surgery, pain management and podiatry services provided in the ASTC setting against a growing population. This project will improve access to those services to the market.*

County Level Map



D. 1). a) Describe the demographics of the population to be served by the proposal.

This multi-specialty ASTC as proposed will serve adults (20 years and over) of all races and ethnicities.

b) Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data: http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data: http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Demographic Variable/Geographic Area	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population - Current Year	Total Population - Projected Year	Total Population -% Change	*Target Population- Current Year	*Target Population- Project Year	*Target Population- % Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total Population
Davidson	689,338	698,061	1%	507,817	512,829	1%	73%	34.2	48,368	114,056	18.2%	140,378	20%
Williamson	220,746	225,526	2%	154,959	159,509	3%	71%	38.9	96,565	9,342	5.1%	12,283	6%
Service Area Total	910,084	923,587	1%	662,776	672,338	1%	73%	35.26		123,398	15%	152,661	17%
State of TN Total	6,887,582	6,962,031	1%	5,114,667	5,176,731	1%	74%	38.4	45,219	1,116,914	17.6%	1,433,463	21%

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2016, then default Projected Year is 2020.*

2) Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

The service area is generally well served across health disparities and accessibility to health care. This project hopes to improve a limited and decreasing case volume in plastic surgery, pain management and podiatry in outpatient ASTCs in Davidson and Williamson counties as those specialties are squeezed out of current ASTCs in favor of more profitable specialties. The reduction is access for the proposed three specialties is evident in the Joint Annual Report data filed by other ASTCs in the market:

Specialty	2014	2015	2016	3-Year Average	2-Year Growth
Plastic Surgery	5,654	2,242	2,034	3,310	-64.03%
Pain Management	27,854	15,597	15,597	19,683	-44.00%
Podiatry	3,471	879	875	1,742	-74.79%

E. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.

Petitioner found no unimplemented similar service providers. Turner Surgery Center is a previously approved ASTC project in Davidson County that may provider similar pain management services, however no Joint Annual Report is currently available.

F. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

	Cases
2014	954
2015	457
2016	449
2017 estimated	475
2018 projected	1000
2019 projected	1000

Dr. DeLozier has historically performed between 440 and 480 procedures per year as reported in his Joint Annual Reports. The addition of pain management and podiatry procedures is anticipated to increase the number of procedures performed by between 500 and 600 procedures annually, reaching a total of approximately 1000 procedures per year.
The additional pain management and podiatry services projected are based upon estimated current volume provided by physicians interested in using the operating room in its current setting.

SECTION B: ECONOMIC FEASIBILITY

A. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

1) All projects should have a project cost of at least $15,000 (the minimum CON Filing Fee). (See Application Instructions for Filing Fee)

2) The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

3) The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

4) Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

5) For projects that include new construction, modification, and/or renovation—**documentation must be** provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

   a) A general description of the project;

   b) An estimate of the cost to construct the project;

   c) A description of the status of the site's suitability for the proposed project; and

   d) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

PROJECT COST CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	10,000.00
3.	Acquisition of Site	
4.	Preparation of Site	
5.	Total Construction Costs	
6.	Contingency Fund	
7.	Fixed Equipment (Not included in Construction Contract)	
8.	Moveable Equipment (List all equipment over $50,000 as separate attachments)	
9.	Other (Specify) _____	
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	
2.	Building only	
3.	Land only	
4.	Equipment (Specify) C-Arm	25,000.00
5.	Other (Specify) _____	
C.	Financing Costs and Fees:	
1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify) _____	
D.	Estimated Project Cost (A+B+C)	
E.	CON Filing Fee	15,000.00
F.	Total Estimated Project Cost (D+E)	**TOTAL** **$50,000.00**

B. Identify the funding sources for this project.

Check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment Section B-Economic Feasibility-B.)***

__ 1) Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

__ 2) Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ 3) General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;

__ 4) Grants – Notification of intent form for grant application or notice of grant award;

_X_ 5) Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or

__ 6) Other – Identify and document funding from all other sources.

C. Complete Historical Data Charts on the following two pages—***Do not modify the Charts provided or submit Chart substitutions!***

Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. **Only complete one chart if it suffices.** *Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.*

X Total Facility
□ Project Only

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

		Year 2014	Year 2015	Year 2016
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits)	954	457	449
B.	Revenue from Services to Patients			
1.	Inpatient Services	$	$	$
2.	Outpatient Services	1,121,275	1,160,928	879,144
3.	Emergency Services			
4.	Other Operating Revenue (Specify)_____			
	Gross Operating Revenue	$ 1,121,275	$ 1,160,928	$879,144
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$527,645	$ 516,782	$ 332,381
2.	Provision for Charity Care			
3.	Provisions for Bad Debt			
	Total Deductions	$ 527,645	$ 516,782	$332,381
NET OPERATING REVENUE		$ 593,630	$ 644,146	$546,763
D.	Operating Expenses			
1.	Salaries and Wages			
	a. Direct Patient Care	363,600	380,000	380,000
	b. Non-Patient Care			
2.	Physician's Salaries and Wages			
3.	Supplies	82,300	74,300	82,900
4.	Rent			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates			
5.	Management Fees:			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates			
6.	Other Operating Expenses			
	Total Operating Expenses	$ 445,900	$ 454,300	$462,900
E.	**Earnings Before Interest, Taxes and Depreciation**	$ 147,730	$ 189,846	$ 83,863
F.	Non-Operating Expenses			
1.	Taxes	$	$	$
2.	Depreciation	14,100	17,200	15,800
3.	Interest			
4.	Other Non-Operating Expenses	9,400	13,200	15,400
	Total Non-Operating Expenses	$ 23,500	$ 30,500	$ 31,200
NET INCOME (LOSS)		$ 124,230	$ 159,346	$52,663

Chart Continues Onto Next Page

NET INCOME (LOSS)	$ 124,230	$ 159,346	$ 52,663
G. Other Deductions			
1. Annual Principal Debt Repayment	$	$	$
2. Annual Capital Expenditure			
Total Other Deductions	$ 0	$ 0	$ 0
NET BALANCE	$ 124,230	$ 159,346	$ 52,663
DEPRECIATION	$ 14,100	$ 17,200	$ 15,800
FREE CASH FLOW (Net Balance + Depreciation)	$ 138,330	$ 176,546	$ 68,463

X Total Facility

☐ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

	OTHER EXPENSES CATEGORIES	**Year 2014**	**Year 2015**	***Year 2016***
1.	Professional Services Contract	$ 0	$ 0	$ 0
2.	Contract Labor	0	0	0
3.	Imaging Interpretation Fees	0	0	0
4.				
5.				
6.				
7.				
	Total Other Expenses	**$ 0**	**$ 0**	**$ 0**

D. Complete Projected Data Charts on the following two pages – ***Do not modify the Charts provided or submit Chart substitutions!***

The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. **Only complete one chart if it suffices.**

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

X Total Facility
□ Project Only

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 2018	Year 2019
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits)	1000	1000
B.	Revenue from Services to Patients		
1.	Inpatient Services		
2.	Outpatient Services	2,000,000	2,000,000
3.	Emergency Services		
4.	Other Operating Revenue (Specify)_____		
	Gross Operating Revenue	**$ 2,000,000**	**$ 2,000,000**
C	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$ 900,000	$ 900,000
2.	Provision for Charity Care		
3.	Provisions for Bad Debt		
	Total Deductions	$900,000	$ 900,000
NET OPERATING REVENUE		$1,100,000	$1,100,000
D.	Operating Expenses		
1.	Salaries and Wages		
	a. Direct Patient Care	650,000	650,000
	b. Non-Patient Care		
2.	Physician's Salaries and Wages		
3.	Supplies	110,000	110,0000
4.	Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates		
5.	Management Fees:		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates		
	c. Other Operating Expenses		
	Total Operating Expenses	$ 760,000	$ 760,000
E.	**Earnings Before Interest, Taxes and Depreciation**	$ 340,000	$ 340,000
F.	Non-Operating Expenses		
1.	Taxes	$	$
2.	Depreciation	18,000	18,000
3.	Interest		
4.	Other Non-Operating Expenses	15,000	15,000
	Total Non-Operating Expenses	$ 33,000	$ 33,000
	NET INCOME (LOSS)	$ 307,000	$ 307,000

Chart Continues Onto Next Page

NET INCOME (LOSS)		$ 307,000	$ 307,000
G.	Other Deductions		
1.	Estimated Annual Principal Debt Repayment	$ 0	$ 0
2.	Annual Capital Expenditure	0	0
	Total Other Deductions	$ 0	$ 0
	NET BALANCE	$ 307,000	$ 307,000
	DEPRECIATION	$ 18,000	$ 18,000
	FREE CASH FLOW (Net Balance + Depreciation)	$ 325,000	$ 325,000

X Total Facility

☐ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

	OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1.	Professional Services Contract	$	$
2.	Contract Labor		
3.	Imaging Interpretation Fees		
4.			
5.			
6.			
7.			
	Total Other Expenses	**$ 0**	**$ 0**

E. 1) Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year	Current Year	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	2,540	1,958	2,000	2,000	2%
Deduction from Revenue *(Total Deductions/Utilization Data)*	1,131	740	900	900	22%
Average Net Charge *(Net Operating Revenue/Utilization Data)*	1,409	1,218	1,100	1,100	-10%

2) Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Management believes the proposed charges will be similar to current charges and involve limited impact on existing patients. Management believes that the incorporation of pain management and podiatry will involve additional deductions from revenue as payers discount for multiple procedures performed in each case that would be at a higher rate than the ASTC currently experiences on plastic surgery cases. This will result in a reduced Net Charge that will be offset by expanded use and improved efficiency in the ASTC.

3) Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Comparison of publicly available data from similar facilities proves difficult with other multi-specialty ASTCs due to the dramatically different specialty case mix and difficulty comparing the respective insurance mix involved in this project as opposed to the broad specialties of other centers.

F. 1) Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as **Attachment Section B-Economic Feasibility-F1. NOTE: Publicly held entities only need to reference their SEC filings.**

DeLozier Surgery Center is currently above the financial breakeven as indicated in the Joint Annual Reports filed. This expansion of service will improve financial performance, diversify the patient population and cases performed resulting in modestly enhanced financial performance.

2) Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio	*25%*	*29%*	*15%*	*31%*	*31%*

3) Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt+Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

No debt will be used to fund this project.

G. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Applicant's Projected Payor Mix, Year 1

Payor Source	**Projected Gross Operating Revenue**	**As a % of total**
Medicare/Medicare Managed Care	*500,000*	*25%*
TennCare/Medicaid		
Commercial/Other Managed Care	*900,000*	*45%*
Self-Pay	*600,000*	*30%*
Charity Care		
Other (Specify)_____		
Total	2,000,000	100%

H. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by

position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Position Classification	Existing FTEs 2017	Projected FTEs Year 1	Average Wage (Contractual Rate)	Area Wide/Statewide Average Wage
a) Direct Patient Care Positions				From Indeed.com
Nurses	*3*	*7*	*$55,000.00*	*$48,484.80*
CRNA	*1*	*1.5*	*$150,000.00*	*$144,310.00*
Total Direct Patient Care Positions	*4*	*9*		
b) Non-Patient Care Positions				
Reception/Scheduler	*1*	*1*	*$35,000.00*	*$25,126.40*
Total Non-Patient Care Positions	*1*	*1*		
c) Contractual Staff	*0*	*2*		
Total Staff	*5*	*12*		

I. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

1) Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

Expanding the use of existing ASTC rooms was more cost effective and efficient than new construction of additional ASTC operating rooms to serve the specialties planned.

2) Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

No new construction is involved in this project.

SECTION B: CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

A. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.

The ASTC currently contracts with Medicare and various commercial managed care organizations including Blue Cross, Cigna, Aetna and United Healthcare. The ASTC has a current transfer agreement with St. Thomas Midtown Hospital. No changes are anticipated in those relationships.

B. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

1) Positive Effects

This proposal will expand the use of the current complement of ASTC beds offering opportunities for greater financial and operational efficiency in the target market. The proposal will allow greater access to care in the proposed specialties which is necessary as demonstrated from the decreased volume of cases in these specialties at existing multi-specialty ASTCs. The proposal should not have adverse impact on existing providers as they have reduced access to the proposed specialties as described in Section B.D.2 above.

2) Negative Effects

No adverse effects are anticipated due to the limited scope of the proposed change.

C. 1) Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

This proposal anticipates no changes that would impact accreditation requirements.

2) Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

The ASTC currently abides by all regulation and accreditation standards. No changes anticipated.

3) Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Applicant does not have current plans to train students.

D. Identify the type of licensure and certification requirements applicable and verify the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure:

Tennessee Department of Health License Expires November 5, 2018

Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.):

Ambulatory Surgical Treatment Center

Accreditation (i.e., Joint Commission, CARF, etc.):

American Association for Accreditation of Ambulatory Surgery Facilities Expires May 2, 2018

1) If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

Attachment B-A9 & Attachment B-D1

2) For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.

Attachment B-D2

3) Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.

Not Applicable

a) Discuss what measures the applicant has or will put in place to avoid similar findings in the future. .

E. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

1) Has any of the following:

a) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

b) Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

c) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

2) Been subjected to any of the following:

a) Final Order or Judgment in a state licensure action;
None

b) Criminal fines in cases involving a Federal or State health care offense;
None

c) Civil monetary penalties in cases involving a Federal or State health care offense;
None

d) Administrative monetary penalties in cases involving a Federal or State health care offense;
None

e) Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or
None

f) Suspension or termination of participation in Medicare or Medicaid/TennCare programs.
None

g) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.
None

h) Is presently subject to a corporate integrity agreement.
None

F. Outstanding Projects:

1) Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

Outstanding Projects

CON Number	Project Name	Date Approved	*Annual Progress Report(s) Due Date	*Annual Progress Report(s) Date Filed	Expiration Date
None					

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

2) Provide a brief description of the current progress, and status of each applicable outstanding CON.

Not Applicable

G. Equipment Registry – For the applicant and all entities in common ownership with the applicant.

Not Applicable

1) Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)? _____

2) If yes, have you submitted their registration to HSDA? If you have, what was the date of submission?_____

3) If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission? _____

SECTION B: QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

The applicant currently reports quality measures and will continue to do so.

SECTION C: STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

A. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

B. People in Tennessee should have access to health care and the conditions to achieve optimal health.

C. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

D. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

E. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

The proposed project will expand the use of 1 existing operating room bed. The expansion from single specialty to multi-specialty will expand access to pain management and podiatry services to the target market. The expansion will allow greater efficiency and more complete use of existing resources to improve the health of Tennessee residents. The existing ASTC participates in licensure and accreditation programs to monitor performance and strive to continuously improve the quality of health care provided. The licensure and accreditation programs provide the vehicle to verify that the ASTC is adhering to appropriate standards. The approval of this project will only enhance the workforce opportunities in the growing target market by expanding the use of current ASTC bed resources and hours of operation providing greater convenience to individuals in the market.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(9)(A) states that "...Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		**2/2018**
2. Architectural and engineering contract signed		
3. Construction documents approved by the Tennessee Department of Health		
4. Construction contract signed		
5. Building permit secured		
6. Site preparation completed		
7. Building construction commenced		
8. Construction 40% complete		
9. Construction 80% complete		
10. Construction 100% complete (approved for occupancy		
11. *Issuance of License		**Current**
12. *Issuance of Service		**3/2018**
13. Final Architectural Certification of Payment		
14. Final Project Report Form submitted (Form HR0055)		

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

Attachment A-4A

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Filing Information

Name: **DELOZIER SURGERY CENTER, LLC**

General Information

SOS Control #	**000449189**	Formation Locale:	TENNESSEE
Filing Type:	Limited Liability Company - Domestic	Date Formed:	06/24/2003
	06/24/2003 10:26 AM	Fiscal Year Close	12
Status:	Active	Member Count:	1
Duration Term:	Perpetual		
Managed By:	Member Managed		

Registered Agent Address
JOSEPH B DELOZIER III M D
209 23RD AVE N
NASHVILLE, TN 37203-1501

Principal Address
209 23RD AVE N
NASHVILLE, TN 37203-1501

The following document(s) was/were filed in this office on the date(s) indicated below:

Date Filed	Filing Description	Image #
02/09/2017	2016 Annual Report	B0344-4005
02/01/2016	2015 Annual Report	B0190-6311
01/13/2015	2014 Annual Report	B0044-0645
02/03/2014	2013 Annual Report	A0212-2397
06/14/2013	2012 Annual Report	A0189-0524
06/04/2013	Notice of Determination	A0179-1733
03/14/2012	2011 Annual Report	A0108-2439
	Principal Address 1 Changed From: 209 23RD AVE NORTH To: 209 23RD AVE N	
	Principal Postal Code Changed From: 37203 To: 37203-1501	
	Principal County Changed From: DAVIDSON To: DAVIDSON COUNTY	
03/30/2011	2010 Annual Report	6866-2117
	Principal County Changed From: Davidson County To: Davidson	
03/29/2010	2009 Annual Report	6687-2201
04/03/2009	2008 Annual Report	6505-2620
03/27/2008	2007 Annual Report	6265-1846
03/21/2007	2006 Annual Report	5994-1152
03/29/2006	2005 Annual Report	5740-2332

Filing Information

Name: **DELOZIER SURGERY CENTER, LLC**

04/04/2005	2004 Annual Report	5415-2577
02/18/2004	2003 Annual Report	5040-0705
06/24/2003	Initial Filing	4847-1343

Active Assumed Names (if any)	Date	Expires

Attachment A-6A

Private Banking – Nashville Branch
401 Union Street
Nashville, TN 37219

WHEN RECORDED MAIL TO:
Union Planters Bank, National Association
Private Banking – Nashville Branch
401 Union Street
Nashville, TN 37219

Davidson County DOT
Recvd: 02/20/01 14:41 9pgs
Fees:39.00 Taxes:880.20
20010220-0015628

OWNER:
Joseph B. DeLozier III, PLLC
5 Buckland Abbey
Nashville, TN 37215

FOR RECORDER'S USE ONLY

This Deed of Trust prepared by:

Name: Union Planters Bank, N.A.
Address: 728 Melrose Avenue
City, State, ZIP: Nashville, TN 37211

DEED OF TRUST

NOTICE: THIS DEED OF TRUST SECURES "OBLIGATORY ADVANCES" AND IS FOR "COMMERCIAL PURPOSES" AS THOSE TERMS ARE DEFINED IN SECTION 47-28-104 OF TENNESSEE CODE ANNOTATED.

MAXIMUM PRINCIPAL INDEBTEDNESS FOR TENNESSEE RECORDING TAX PURPOSES IS $750,000.00.

THIS DEED OF TRUST is dated February 20, 2001, among Joseph B. DeLozier III, PLLC, whose address is 5 Buckland Abbey, Nashville, TN 37215 ("Grantor"); Union Planters Bank, National Association, whose address is Private Banking – Nashville Branch, 401 Union Street, Nashville, TN 37219 (referred to below sometimes as "Lender" and sometimes as "Beneficiary"); and Vaden Lackey, Jr., whose address is 424 Church Street, Suite 2800, Nashville, TN 37219 (referred to below as "Trustee").

CONVEYANCE AND GRANT. For and in consideration of Five Dollars ($5.00) cash in hand paid, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Grantor has bargained and sold, and does hereby bargain, sell, convey and confirm unto the Trustee in trust, with Power of Sale, for the benefit of Lender as Beneficiary, all of Grantor's right, title, and interest in and to the following described real property, together with all existing or subsequently erected or affixed buildings, improvements and fixtures; all easements, rights of way, and appurtenances; all water, water rights and ditch rights (including stock in utilities with ditch or irrigation rights); and all other rights, royalties, and profits relating to the real property, including without limitation all minerals, oil, gas, geothermal and similar matters, (the "Real Property") located in Davidson County, State of Tennessee:

See attached exhibit "A", which is attached to this Deed of Trust and made a part of this Deed of Trust as if fully set forth herein.

The Real Property or its address is commonly known as 209 23rd Avenue , Nashville, TN 37203.

REVOLVING LINE OF CREDIT. Specifically, in addition to the amounts specified in the Indebtedness definition, and without limitation, this Deed of Trust secures a revolving line of credit,under which Lender may make advances to Grantor up to the maximum principal indebtedness of $750,000.00 so long as Grantor complies with all the terms of the Note.

Grantor presently assigns to Lender (also known as Beneficiary in this Deed of Trust) all of Grantor's right, title, and interest in and to all present and future leases of the Property and all Rents from the Property. In addition, Grantor grants to Lender a Uniform Commercial Code security interest in the Personal Property and Rents.

THIS DEED OF TRUST, INCLUDING THE ASSIGNMENT OF RENTS AND THE SECURITY INTEREST IN THE RENTS AND PERSONAL PROPERTY, IS GIVEN TO SECURE (A) PAYMENT OF THE INDEBTEDNESS AND (B) PERFORMANCE OF ANY AND ALL OBLIGATIONS UNDER THE NOTE, THE RELATED DOCUMENTS, AND THIS DEED OF TRUST. THIS DEED OF TRUST IS GIVEN AND ACCEPTED ON THE FOLLOWING TERMS:

PAYMENT AND PERFORMANCE. Except as otherwise provided in this Deed of Trust, Grantor shall pay to Lender all amounts secured by this Deed of Trust as they become due, and shall strictly and in a timely manner perform all of Grantor's obligations under the Note, this Deed of Trust, and the Related Documents.

POSSESSION AND MAINTENANCE OF THE PROPERTY. Grantor agrees that Grantor's possession and use of the Property shall be governed by the following provisions:

Possession and Use. Until the occurrence of an Event of Default, Grantor may (1) remain in possession and control of the Property; (2) use, operate or manage the Property; and (3) collect the Rents from the Property.

Duty to Maintain. Grantor shall maintain the Property in tenantable condition and promptly perform all repairs, replacements, and maintenance necessary to preserve its value.

ownership of the Property, there has been no use, generation, manufacture, storage, treatment, disposal, release or threatened release of any Hazardous Substance by any person on, under, about or from the Property; (2) Grantor has no knowledge of, or reason to believe that there has been, except as previously disclosed to and acknowledged by Lender in writing, (a) any breach or violation of any Environmental Laws, (b) any use, generation, manufacture, storage, treatment, disposal, release or threatened release of any Hazardous Substance on, under, about or from the Property by any prior owners or occupants of the Property, or (c) any actual or threatened litigation or claims of any kind by any person relating to such matters; and (3) Except as previously disclosed to and acknowledged by Lender in writing, (a) neither Grantor nor any tenant, contractor, agent or other authorized user of the Property shall use, generate, manufacture, store, treat, dispose of or release any Hazardous Substance on, under, about or from the Property; and (b) any such activity shall be conducted in compliance with all applicable federal, state, and local laws, regulations and ordinances, including without limitation all Environmental Laws. Grantor authorizes Lender and its agents to enter upon the Property to make such inspections and tests, at Grantor's expense, as Lender may deem appropriate to determine compliance of the Property with this section of the Deed of Trust. Any inspections or tests made by Lender shall be for Lender's purposes only and shall not be construed to create any responsibility or liability on the part of Lender to Grantor or to any other person. The representations and warranties contained herein are based on Grantor's due diligence in investigating the Property for Hazardous Substances. Grantor hereby (1) releases and waives any future claims against Lender for indemnity or contribution in the event Grantor becomes liable for cleanup or other costs under any such laws; and (2) agrees to indemnify and hold harmless Lender against any and all claims, losses, liabilities, damages, penalties, and expenses which Lender may directly or indirectly sustain or suffer resulting from a breach of this section of the Deed of Trust or as a consequence of any use, generation, manufacture, storage, disposal, release or threatened release occurring prior to Grantor's ownership or interest in the Property, whether or not the same was or should have been known to Grantor. The provisions of this section of the Deed of Trust, including the obligation to indemnify, shall survive the payment of the Indebtedness and the satisfaction and reconveyance of the lien of this Deed of Trust and shall not be affected by Lender's acquisition of any interest in the Property, whether by foreclosure or otherwise.

Nuisance, Waste. Grantor shall not cause, conduct or permit any nuisance nor commit, permit, or suffer any stripping of or waste on or to the Property or any portion of the Property. Without limiting the generality of the foregoing, Grantor will not remove, or grant to any other party the right to remove, any timber, minerals (including oil and gas), coal, clay, scoria, soil, gravel or rock products without Lender's prior written consent.

Removal of Improvements. Grantor shall not demolish or remove any Improvements from the Real Property without Lender's prior written consent. As a condition to the removal of any Improvements, Lender may require Grantor to make arrangements satisfactory to Lender to replace such Improvements with Improvements of at least equal value.

Lender's Right to Enter. Lender and Lender's agents and representatives may enter upon the Real Property at all reasonable times to attend to Lender's interests and to inspect the Real Property for purposes of Grantor's compliance with the terms and conditions of this Deed of Trust.

Compliance with Governmental Requirements. Grantor shall promptly comply with all laws, ordinances, and regulations, now or hereafter in effect, of all governmental authorities applicable to the use or occupancy of the Property, including without limitation, the Americans With Disabilities Act. Grantor may contest in good faith any such law, ordinance, or regulation and withhold compliance during any proceeding, including appropriate appeals, so long as Grantor has notified Lender in writing prior to doing so and so long as, in Lender's sole opinion, Lender's interests in the Property are not jeopardized. Lender may require Grantor to post adequate security or a surety bond, reasonably satisfactory to Lender, to protect Lender's interest.

Duty to Protect. Grantor agrees neither to abandon nor leave unattended the Property. Grantor shall do all other acts, in addition to those acts set forth above in this section, which from the character and use of the Property are reasonably necessary to protect and preserve the Property.

TAXES AND LIENS. The following provisions relating to the taxes and liens on the Property are part of this Deed of Trust:

Payment. Grantor shall pay when due (and in all events prior to delinquency) all taxes, special taxes, assessments, charges (including water and sewer), fines and impositions levied against or on account of the Property, and shall pay when due all claims for work done on or for services rendered or material furnished to the Property. Grantor shall maintain the Property free of all liens having priority over or equal to the interest of Lender under this Deed of Trust, except for the lien of taxes and assessments not due and except as otherwise provided in this Deed of Trust.

Right to Contest. Grantor may withhold payment of any tax, assessment, or claim in connection with a good faith dispute over the obligation to pay, so long as Lender's interest in the Property is not jeopardized. If a lien arises or is filed as a result of nonpayment, Grantor shall within fifteen (15) days after the lien arises or, if a lien is filed, within fifteen (15) days after Grantor has notice of the filing, secure the discharge of the lien, or if requested by Lender, deposit with Lender cash or a sufficient corporate surety bond or other security satisfactory to Lender in an amount sufficient to discharge the lien plus any costs and attorneys' fees, or other charges that could accrue as a result of a foreclosure or sale under the lien. In any contest, Grantor shall defend itself and Lender and shall satisfy any adverse judgment before enforcement against the Property. Grantor shall name Lender as an additional obligee under any surety bond furnished in the contest proceedings.

Evidence of Payment. Grantor shall upon demand furnish to Lender satisfactory evidence of payment of the taxes or assessments and shall authorize the appropriate governmental official to deliver to Lender at any time a written statement of the taxes and assessments against the Property.

Notice of Construction. Grantor shall notify Lender at least fifteen (15) days before any work is commenced, any services are furnished, or any materials are supplied to the Property, if any mechanic's lien, materialmen's lien, or other lien could be asserted on account of the work, services, or materials. Grantor will upon request of Lender furnish to Lender advance assurances satisfactory to Lender that Grantor can and will pay the cost of such improvements.

PROPERTY DAMAGE INSURANCE. The following provisions relating to insuring the Property are a part of this Deed of Trust.

Maintenance of Insurance. Grantor shall procure and maintain policies of fire insurance with standard extended coverage endorsements on a replacement basis for the full insurable value covering all Improvements on the Real Property in an amount sufficient to avoid application of any coinsurance clause, and with a standard mortgagee clause in favor of Lender. Grantor shall also procure and maintain comprehensive general liability insurance in such coverage amounts as Lender may request with

Trustee. The word "Trustee" means Vaden Lackey, Jr., whose address is 424 Church Street, Suite 2800, Nashville, TN 37219 and any substitute or successor trustees. and Lender being named as additional insureds in such liability insurance policies. Additionally, Grantor shall maintain such other insurance, including but not limited to hazard, business interruption, and boiler insurance, as Lender may reasonably require. Policies shall be written in form, amounts, coverages and basis reasonably acceptable to Lender and issued by a company or companies reasonably acceptable to Lender. Grantor, upon request of Lender, will deliver to Lender from time to time the policies or certificates of insurance in form satisfactory to Lender, including stipulations that coverages will not be cancelled or diminished without at least thirty (30) days prior written notice to Lender. Each insurance policy also shall include an endorsement providing that coverage in favor of Lender will not be impaired in any way by any act, omission or default of Grantor or any other person. Should the Real Property be located in an area designated by the Director of the Federal Emergency Management Agency as a special flood hazard area, Grantor agrees to obtain and maintain Federal Flood Insurance, if available, within 45 days after notice is given by Lender that the Property is located in a special flood hazard area, for

of the loan.

Application of Proceeds. Grantor shall promptly notify Lender of any loss or damage to the Property. Lender may make proof of loss if Grantor fails to do so within fifteen (15) days of the casualty. Whether or not Lender's security is impaired, Lender may, at Lender's election, receive and retain the proceeds of any insurance and apply the proceeds to the reduction of the Indebtedness, payment of any lien affecting the Property, or the restoration and repair of the Property. If Lender elects to apply the proceeds to restoration and repair, Grantor shall repair or replace the damaged or destroyed Improvements in a manner satisfactory to Lender. Lender shall, upon satisfactory proof of such expenditure, pay or reimburse Grantor from the proceeds for the reasonable cost of repair or restoration if Grantor is not in default under this Deed of Trust. Any proceeds which have not been disbursed within 180 days after their receipt and which Lender has not committed to the repair or restoration of the Property shall be used first to pay any amount owing to Lender under this Deed of Trust, then to pay accrued interest, and the remainder, if any, shall be applied to the principal balance of the Indebtedness. If Lender holds any proceeds after payment in full of the Indebtedness, such proceeds shall be paid to Grantor as Grantor's interests may appear.

Unexpired Insurance at Sale. Any unexpired insurance shall inure to the benefit of, and pass to, the purchaser of the Property covered by this Deed of Trust at any trustee's sale or other sale held under the provisions of this Deed of Trust, or at any foreclosure sale of such Property.

Grantor's Report on Insurance. Upon request of Lender, however not more than once a year, Grantor shall furnish to Lender a report on each existing policy of insurance showing: (1) the name of the insurer; (2) the risks insured; (3) the amount of the policy; (4) the property insured, the then current replacement value of such property, and the manner of determining that value; and (5) the expiration date of the policy. Grantor shall, upon request of Lender, have an independent appraiser satisfactory to Lender determine the cash value replacement cost of the Property.

LENDER'S EXPENDITURES. If any action or proceeding is commenced that would materially affect Lender's interest in the Property or if Grantor fails to comply with any provision of this Deed of Trust or any Related Documents, including but not limited to Grantor's failure to discharge or pay when due any amounts Grantor is required to discharge or pay under this Deed of Trust or any Related Documents, Lender on Grantor's behalf may (but shall not be obligated to) take any action that Lender deems appropriate, including but not limited to discharging or paying all taxes, liens, security interests, encumbrances and other claims, at any time levied or placed on the Property and paying all costs for insuring, maintaining and preserving the Property. All such expenditures incurred or paid by Lender for such purposes will then bear interest at the rate charged under the Note from the date incurred or paid by Lender to the date of repayment by Grantor. All such expenses will become a part of the Indebtedness and, at Lender's option, will (A) be payable on demand; (B) be added to the balance of the Note and be apportioned among and be payable with any installment payments to become due during either (1) the term of any applicable insurance policy; or (2) the remaining term of the Note; or (C) be treated as a balloon payment which will be due and payable at the Note's maturity. The Deed of Trust also will secure payment of these amounts. Such right shall be in addition to all other rights and remedies to which Lender may be entitled upon Default.

WARRANTY; DEFENSE OF TITLE. The following provisions relating to ownership of the Property are a part of this Deed of Trust:

Title. Grantor warrants that: (a) Grantor holds good and marketable title of record to the Property in fee simple, free and clear of all liens and encumbrances other than those set forth in the Real Property description or in any title insurance policy, title report, or final title opinion issued in favor of, and accepted by, Lender in connection with this Deed of Trust, and (b) Grantor has the full right, power, and authority to execute and deliver this Deed of Trust to Lender.

Defense of Title. Subject to the exception in the paragraph above, Grantor warrants and will forever defend the title to the Property against the lawful claims of all persons. In the event any action or proceeding is commenced that questions Grantor's title or the interest of Trustee or Lender under this Deed of Trust, Grantor shall defend the action at Grantor's expense. Grantor may be the nominal party in such proceeding, but Lender shall be entitled to participate in the proceeding and to be represented in the proceeding by counsel of Lender's own choice, and Grantor will deliver, or cause to be delivered, to Lender such instruments as Lender may request from time to time to permit such participation.

Compliance With Laws. Grantor warrants that the Property and Grantor's use of the Property complies with all existing applicable laws, ordinances, and regulations of governmental authorities.

Survival of Representations and Warranties. All representations, warranties, and agreements made by Grantor in this Deed of Trust shall survive the execution and delivery of this Deed of Trust, shall be continuing in nature, and shall remain in full force and effect until such time as Grantor's Indebtedness shall be paid in full.

CONDEMNATION. The following provisions relating to condemnation proceedings are a part of this Deed of Trust:

Proceedings. If any proceeding in condemnation is filed, Grantor shall promptly notify Lender in writing, and Grantor shall promptly take such steps as may be necessary to defend the action and obtain the award. Grantor may be the nominal party in such proceeding, but Lender shall be entitled to participate in the proceeding and to be represented in the proceeding by counsel of its own choice, and Grantor will deliver or cause to be delivered to Lender such instruments and documentation as may be requested by Lender from time to time to permit such participation.

Application of Net Proceeds. If all or any part of the Property is condemned by eminent domain proceedings or by any proceeding or purchase in lieu of condemnation, Lender may at its election require that all or any portion of the net proceeds of the award be applied to the Indebtedness or the repair or restoration of the Property. The net proceeds of the award shall mean the award after payment of all reasonable costs, expenses, and attorneys' fees incurred by Trustee or Lender in connection with the condemnation.

IMPOSITION OF TAXES, FEES AND CHARGES BY GOVERNMENTAL AUTHORITIES. The following provisions relating to governmental taxes, fees and charges are a part of this Deed of Trust:

Current Taxes, Fees and Charges. Upon request by Lender, Grantor shall execute such documents in addition to this Deed of Trust and take whatever other action is requested by Lender to perfect and continue Lender's lien on the Real Property. Grantor shall reimburse Lender for all taxes, as described below, together with all expenses incurred in recording, perfecting or continuing this Deed of Trust, including without limitation all taxes, fees, documentary stamps, and other charges for recording or registering this Deed of Trust.

Taxes. The following shall constitute taxes to which this section applies: (1) a specific tax upon this type of Deed of Trust or upon all or any part of the Indebtedness secured by this Deed of Trust; (2) a specific tax on Grantor which Grantor is authorized or required to deduct from payments on the Indebtedness secured by this type of Deed of Trust; (3) a tax on this type of Deed of Trust chargeable against the Lender or the holder of the Note; and (4) a specific tax on all or any portion of the Indebtedness or on payments of principal and interest made by Grantor.

Subsequent Taxes. If any tax to which this section applies is enacted subsequent to the date of this Deed of Trust, this event shall have the same effect as an Event of Default, and Lender may exercise any or all of its available remedies for an Event of Default as provided below unless Grantor either (1) pays the tax before it becomes delinquent, or (2) contests the tax as provided above in the Taxes and Liens section and deposits with Lender cash or a sufficient corporate surety bond or other security satisfactory to Lender.

SECURITY AGREEMENT; FINANCING STATEMENTS.

Security Agreement. This instrument shall constitute a Security Agreement to the extent any of the Property constitutes fixtures or other personal property, and Lender shall have all of the rights of a secured party under the Uniform Commercial Code as amended from time to time.

Security Interest. Upon request by Lender, Grantor shall execute financing statements and take whatever other action is requested by Lender to perfect and continue Lender's security interest in the Rents and Personal Property. In addition to recording this Deed of Trust in the real property records, Lender may, at any time and without further authorization from Grantor, file executed counterparts, copies or reproductions of this Deed of Trust as a financing statement. Grantor shall reimburse Lender for all expenses incurred in perfecting or continuing this security interest. Upon default, Grantor shall assemble the Personal Property in a manner and at a place reasonably convenient to Grantor and Lender and make it available to Lender within three (3) days after receipt of written demand from Lender.

Addresses. The mailing addresses of Grantor (debtor) and Lender (secured party) from which information concerning the security interest granted by this Deed of Trust may be obtained (each as required by the Uniform Commercial Code) are as stated on the first page of this Deed of Trust.

FURTHER ASSURANCES; ATTORNEY-IN-FACT. The following provisions relating to further assurances and attorney-in-fact are a part of this Deed of Trust:

Further Assurances. At any time, and from time to time, upon request of Lender, Grantor will make, execute and deliver, or will cause to be made, executed or delivered, to Lender or to Lender's designee, and when requested by Lender, cause to be filed, recorded, refiled, or rerecorded, as the case may be, at such times and in such offices and places as Lender may deem appropriate, any and all such mortgages, deeds of trust, security deeds, security agreements, financing statements, continuation statements, instruments of further assurance, certificates, and other documents as may, in the sole opinion of Lender, be necessary or desirable in order to effectuate, complete, perfect, continue, or preserve (1) Grantor's obligations under the Note, this Deed of Trust, and the Related Documents, and (2) the liens and security interests created by this Deed of Trust as first and prior liens on the Property, whether now owned or hereafter acquired by Grantor. Unless prohibited by law or Lender agrees to the contrary in writing, Grantor shall reimburse Lender for all costs and expenses incurred in connection with the matters referred to in this paragraph.

Attorney-in-Fact. If Grantor fails to do any of the things referred to in the preceding paragraph, Lender may do so for and in the name of Grantor and at Grantor's expense. For such purposes, Grantor hereby irrevocably appoints Lender as Grantor's attorney-in-fact for the purpose of making, executing, delivering, filing, recording, and doing all other things as may be necessary or desirable, in Lender's sole opinion, to accomplish the matters referred to in the preceding paragraph.

FULL PERFORMANCE. If Grantor shall well and truly pay and perform the obligations at the time and times, and in the manner mentioned in this Deed of Trust, and shall well and truly abide by and comply with each and every term, covenant and condition set forth in this Deed of Trust, then this conveyance shall be and become null and void and the Trustee shall convey the Property to the Grantor by release deed at Grantor's expense.

EVENTS OF DEFAULT. Each of the following, at Lender's option, shall constitute an Event of Default under this Deed of Trust:

Payment Default. Grantor fails to make any payment when due under the Indebtedness.

Other Defaults. Grantor fails to comply with or to perform any other term, obligation, covenant or condition contained in this Deed of Trust or in any of the Related Documents or to comply with or to perform any term, obligation, covenant or condition contained in any other agreement between Lender and Grantor.

Compliance Default. Failure to comply with any other term, obligation, covenant or condition contained in this Deed of Trust, the Note or in any of the Related Documents. If such a failure is curable and if Grantor has not been given a notice of a breach of the same provision of this Deed of Trust within the preceding twelve (12) months, it may be cured (and no Event of Default will have occurred) if Grantor, after Lender sends written notice demanding cure of such failure: (a) cures the failure within fifteen (15) days; or (b) if the cure requires more than fifteen (15) days, immediately initiates steps sufficient to cure the failure and thereafter continues and completes all reasonable and necessary steps sufficient to produce compliance as soon as reasonably practical.

Default on Other Payments. Failure of Grantor within the time required by this Deed of Trust to make any payment for taxes or insurance, or any other payment necessary to prevent filing of or to effect discharge of any lien.

False Statements. Any warranty, representation or statement made or furnished to Lender by Grantor or on Grantor's behalf under this Deed of Trust, the Note, or the Related Documents is false or misleading in any material respect, either now or at the time made or furnished or becomes false or misleading at any time thereafter.

Defective Collateralization. This Deed of Trust or any of the Related Documents ceases to be in full force and effect (including failure of any collateral document to create a valid and perfected security interest or lien) at any time and for any reason.

Death or Insolvency. The dissolution of Grantor's (regardless of whether election to continue is made), any member withdraws from the limited liability company, or any other termination of Grantor's existence as a going business or the death of any member, the insolvency of Grantor, the appointment of a receiver for any part of Grantor's property, any assignment for the benefit of creditors, any type of creditor workout, or the commencement of any proceeding under any bankruptcy or insolvency laws by or against Grantor.

Creditor or Forfeiture Proceedings. Commencement of foreclosure or forfeiture proceedings, whether by judicial proceeding, self-help, repossession or any other method, by any creditor of Grantor or by any governmental agency against any property securing the Indebtedness. This includes a garnishment of any of Grantor's accounts, including deposit accounts, with Lender. However, this Event of Default shall not apply if there is a good faith dispute by Grantor as to the validity or reasonableness of the claim which is the basis of the creditor or forfeiture proceeding and if Grantor gives Lender written notice of the creditor or forfeiture proceeding and deposits with Lender monies or a surety bond for the creditor or forfeiture proceeding, in an amount determined by Lender, in its sole discretion, as being an adequate reserve or bond for the dispute.

Breach of Other Agreement. Any breach by Grantor under the terms of any other agreement between Grantor and Lender that is not remedied within any grace period provided therein, including without limitation any agreement concerning any indebtedness or other obligation of Grantor to Lender, whether existing now or later.

Events Affecting Guarantor. Any of the preceding events occurs with respect to any Guarantor of any of the Indebtedness or any Guarantor dies or becomes incompetent, or revokes or disputes the validity of, or liability under, any Guaranty of the Indebtedness. In the event of a death, Lender, at its option, may, but shall not be required to, permit the Guarantor's estate to assume unconditionally the obligations arising under the guaranty in a manner satisfactory to Lender, and, in doing so, cure any Event of Default.

Adverse Change. A material adverse change occurs in Grantor's financial condition, or Lender believes the prospect of payment or performance of the Indebtedness is impaired.

Insecurity. Lender in good faith believes itself insecure.

Right to Cure. If such a failure is curable and if Grantor [illegible]

requires more than fifteen (15) days, immediately initiates steps sufficient to cure the failure and thereafter continues and completes all reasonable and necessary steps sufficient to produce compliance as soon as reasonably practical.

RIGHTS AND REMEDIES ON DEFAULT. If an Event of Default occurs under this Deed of Trust, at any time thereafter, Trustee or Lender may exercise any one or more of the following rights and remedies:

Election of Remedies. Election by Lender to pursue any remedy shall not exclude pursuit of any other remedy, and an election to make expenditures or to take action to perform an obligation of Grantor under this Deed of Trust, after Grantor's failure to perform, shall not affect Lender's right to declare a default and exercise its remedies.

Accelerate Indebtedness. Lender shall have the right at its option without notice to Grantor, the same being expressly waived, to declare the entire Indebtedness immediately due and payable, including (if permitted by applicable law) any prepayment penalty for which Grantor may be obligated.

Foreclosure. With respect to all or any part of the Real Property, (a) the Trustee, at the Lender's request, shall have the right to enter and take possession of the Real Property and to sell all or part of the Real Property, at public auction, to the highest bidder for cash, free from equity of redemption, and any statutory or common law right of redemption, homestead, dower, marital share, and all other exemptions, after giving notice of the time, place and terms of such sale and of the Real Property to be sold as required by law, or (b) the Trustee or the Lender shall have the right to foreclose by judicial proceeding, in accordance with and to the full extent provided by applicable law.

UCC Remedies. With respect to all or any part of the Personal Property, Lender shall have all the rights and remedies of a secured party under the Uniform Commercial Code.

Collect Rents. Lender shall have the right, without notice to Grantor to take possession of and manage the Property and collect the Rents, including amounts past due and unpaid, and apply the net proceeds, over and above Lender's costs, against the Indebtedness. In furtherance of this right, Lender may require any tenant or other user of the Property to make payments of rent or use fees directly to Lender. If the Rents are collected by Lender, then Grantor irrevocably designates Lender as Grantor's attorney-in-fact to endorse instruments received in payment thereof in the name of Grantor and to negotiate the same and collect the proceeds. Payments by tenants or other users to Lender in response to Lender's demand shall satisfy the obligations for which the payments are made, whether or not any proper grounds for the demand existed. Lender may exercise its rights under this subparagraph either in person, by agent, or through a receiver.

Appoint Receiver. Lender shall have the right to make application to a court of competent jurisdiction to have a receiver appointed to take possession of all or any part of the Property, with the power to protect and preserve the Property, to operate the Property prior to foreclosure or sale, and to collect the Rents from the Property and apply the proceeds, over and above the cost of the receivership, against the Indebtedness. Lender shall have the right to have a receiver appointed to take possession of all or any part of the Property, with the power to protect and preserve the Property, to operate the Property preceding foreclosure or sale, and to collect the Rents from the Property and apply the proceeds, over and above the cost of the receivership, against the Indebtedness. The receiver may serve without bond if permitted by law. Lender's right to the appointment of a receiver shall exist whether or not the apparent value of the Property exceeds the Indebtedness by a substantial amount. Employment by Lender shall not disqualify a person from serving as a receiver.

Tenancy at Sufferance. If Grantor remains in possession of the Property after the Property is sold as provided above or Lender otherwise becomes entitled to possession of the Property upon default of Grantor, Grantor shall become a tenant at sufferance of Lender or the purchaser of the Property and shall, at Lender's option, either (1) pay a reasonable rental for the use of the Property, or (2) vacate the Property immediately upon the demand of Lender.

Other Remedies. Trustee or Lender shall have any other right or remedy provided in this Deed of Trust or the Note or by law.

Notice of Sale. Lender shall give Grantor reasonable notice of the time and place of any public sale of the Personal Property or of the time after which any private sale or other intended disposition of the Personal Property is to be made. Reasonable notice shall mean notice given at least ten (10) days before the time of the sale or disposition. Any sale of Personal Property may be made in conjunction with any sale of the Real Property.

Sale of the Property. To the extent permitted by applicable law, Grantor hereby waives any and all rights to have the Property marshalled, the equity of redemption, any statutory or common law right of redemption, homestead, dower, marital share and all other exemptions and other rights which might defeat, reduce or affect the right of the Lender to sell the Real Property or the Personal Property for the collection of the Indebtedness. Lender shall give notice to Grantor prior to acceleration following Grantor's breach of any covenant or agreement in this Deed of Trust. The notice shall specify: (a) the default; (b) the action required to cure the default; (c) a date, not less than thirty (30) days from the date the notice is given to Grantor, by which the default must be cured; and (d) that failure to cure the default on or before the date specified in the notice may result in acceleration of the sums secured by this Security Instrument and sale of the Property. If the default is not cured on or before the date specified in the notice, Lender at its option may require immediate payment in full of all sums secured by this Security Instrument without further demand and may invoke the power of sale and any other remedies permitted by applicable law. Lender shall be entitled to collect all expenses incurred in pursuing the remedies provided in this paragraph, including but not limited to, reasonable attorneys' fees and costs of title evidence.

If Lender invokes the power of sale, Trustee shall give notice of sale by public advertisement in the county in which the Property is located for the time and in the manner provided by applicable law, and Lender or Trustee shall mail a copy of the notice of sale to Grantor. Trustee, without demand on Grantor, shall sell the Property at public auction to the highest bidder at the time and under the terms designated in the notice of sale. Lender or its designee may purchase the Property at any sale.

Trustee shall deliver to the purchaser Trustee's deed conveying that Real Property without any covenant or warranty, express or implied. The recitals in the Trustee's deed shall be prima facie evidence of the truth of the statements made therein. Trustee shall apply the proceeds of the sale in the following order: (a) to all expenses of the sale, including, but not limited to, reasonable Trustee's and attorneys' fees; (b) to all sums secured by this Security Instrument; and (c) any excess to the person or persons legally entitled to it. If the Property is sold pursuant to this paragraph, Grantor, or any person holding possession of the Real Property through Grantor, shall immediately surrender possession of the Real Property to the purchaser at the sale. If possession is not surrendered, Grantor or such person shall be a tenant at will of the purchaser and hereby agrees to pay the purchaser the reasonable rental value of the Real Property after sale.

Attorneys' Fees; Expenses. If Lender institutes any suit or action to enforce any of the terms of this Deed of Trust, Lender shall be entitled to recover such sum as the court may adjudge reasonable as attorneys' fees at trial and upon any appeal. Whether or not any court action is involved, and to the extent not prohibited by law, all reasonable expenses Lender incurs that in Lender's opinion are necessary at any time for the protection of its interest or the enforcement of its rights shall become a part of the Indebtedness payable on demand and shall bear interest at the Note rate from the date of the expenditure until repaid. Expenses covered by this paragraph include, without limitation, however subject to any limits under applicable law, Lender's attorneys' fees and Lender's legal expenses, whether or not there is a lawsuit, including attorneys' fees and expenses for bankruptcy proceedings (including efforts to modify or vacate any automatic stay or injunction), appeals, and any anticipated post-judgment collection services, the cost of searching records, obtaining title reports (including foreclosure reports), surveyors' reports, and appraisal fees, title insurance, and fees for the Trustee, to the extent permitted by applicable law. Grantor also will pay any court costs, in addition to all other sums provided by law.

POWERS AND OBLIGATIONS OF TRUSTEE. The following provisions relating to the powers and obligations of Trustee are part of this Deed of Trust:

Powers of Trustee. In addition to all powers of Trustee arising as a matter of law, Trustee shall have the power to take the following actions with respect to the Property upon the written request of Lender and Grantor: (a) join in preparing and filing a map or plat of the Real Property, including the dedication of streets or other rights to the public; (b) join in granting any easement or creating any restriction on the Real Property; and (c) join in any subordination or other agreement affecting this Deed of Trust or the interest of Lender under this Deed of Trust.

Indemnification of Trustee. Grantor agrees to indemnify Trustee for all reasonable costs, charges, and attorneys' fees incurred by Trustee if Trustee is made a party to or intervenes in any action or proceeding affecting the Property, the title to the Property, or the interest of the Trustee or the Lender under this Deed of Trust.

Obligations to Notify. Trustee shall not be obligated to notify any other party of a pending sale under any other trust deed or lien, or of any action or proceeding in which Grantor, Lender, or Trustee shall be a party, unless the action or proceeding is brought by Trustee.

Trustee. Trustee shall meet all qualifications required for Trustee under applicable law. In addition to the rights and remedies set forth above, with respect to all or any part of the Property, the Trustee shall have the right to foreclose by notice and sale, and Lender shall have the right to foreclose by judicial foreclosure, in either case in accordance with and to the full extent provided by applicable law. Trustee shall have the authority, in Trustee's discretion, to employ all proper agents and attorneys in the execution of Trustee's duties under this Deed of Trust and in conducting any sale made pursuant to the terms of this Deed of Trust and to pay for the services rendered by such agents and attorneys out of the proceeds of the sale of the Property. If no sale is made, or if the proceeds of the sale are insufficient to pay such agents and attorneys, then Grantor agrees to pay the cost of such services. The parties in interest hereby waive the necessity of Trustee making oath, filing inventory, or giving bond as security for the execution of this trust, as may be required by the laws of Tennessee.

Successors and Assigns. In the event of the death, refusal, or of inability for any cause, on the part of Trustee named in this Deed of Trust, or of any successor trustee, to act at any time when action under the foregoing powers and trust may be required, or for any other reason satisfactory to Lender, Lender is authorized, either in Lender's own name or through an attorney or attorneys in fact appointed for that purpose, by written instrument duly registered, to name and appoint a successor or successors to execute this trust, such appointment to be evidenced by writing, duly acknowledged; and when such writing shall have been registered, the substituted trustee named therein shall thereupon be vested with all the right and title, and clothed with all the power of the Trustee named in this Deed of Trust and such like power of substitution shall continue so long as any part of the debt secured by this Deed of Trust remains unpaid.

NOTICES. Any notice required to be given under this Deed of Trust, including without limitation any notice of default and any notice of sale shall be given in writing, and shall be effective when actually delivered, when actually received by telefacsimile (unless otherwise required by law), when deposited with a nationally recognized overnight courier, or, if mailed, when deposited in the United States mail, as first class, certified or registered mail postage prepaid, directed to the addresses shown near the beginning of this Deed of Trust. All copies of notices of foreclosure from the holder of any lien which has priority over this Deed of Trust shall be sent to Lender's address, as shown near the beginning of this Deed of Trust. Any party may change its address for notices under this Deed of Trust by giving formal written notice to the other parties, specifying that the purpose of the notice is to change the party's address. For notice purposes, Grantor agrees to keep Lender informed at all times of Grantor's current address. Unless otherwise provided or required by law, if there is more than one Grantor, any notice given by Lender to any Grantor is deemed to be notice given to all Grantors.

MISCELLANEOUS PROVISIONS. The following miscellaneous provisions are a part of this Deed of Trust:

Amendments. This Deed of Trust, together with any Related Documents, constitutes the entire understanding and agreement of the parties as to the matters set forth in this Deed of Trust. No alteration of or amendment to this Deed of Trust shall be effective unless given in writing and signed by the party or parties sought to be charged or bound by the alteration or amendment.

Annual Reports. If the Property is used for purposes other than Grantor's residence, Grantor shall furnish to Lender, upon request, a certified statement of net operating income received from the Property during Grantor's previous fiscal year in such form and detail as Lender shall require. "Net operating income" shall mean all cash receipts from the Property less all cash expenditures made in connection with the operation of the Property.

Arbitration. Grantor and Lender agree that all disputes, claims and controversies between them whether individual, joint, or class in nature, arising from this Deed of Trust or otherwise, including without limitation contract and tort disputes, shall be arbitrated pursuant to the Rules of the American Arbitration Association in effect at the time the claim is filed, upon request of either party. No act to take or dispose of any Property shall constitute a waiver of this arbitration agreement or be prohibited by this arbitration agreement. This includes, without limitation, obtaining injunctive relief or a temporary restraining order; invoking a power of sale under any deed of trust or mortgage; obtaining a writ of attachment or imposition of a receiver; or exercising any rights relating to personal property, including taking or disposing of such property with or without judicial process pursuant to Article 9 of the Uniform Commercial Code. Any disputes, claims, or controversies concerning the lawfulness or reasonableness of any act, or exercise of any right, concerning any Property, including any claim to rescind, reform, or otherwise modify any agreement relating to the Property, shall also be arbitrated, provided however that no arbitrator shall have the right or the power to enjoin or restrain any act of any party. Judgment upon any award rendered by any arbitrator may be entered in any court having jurisdiction. Nothing in this Deed of Trust shall preclude any party from seeking equitable relief from a court of competent jurisdiction. The statute of limitations, estoppel, waiver, laches, and similar doctrines which would otherwise be applicable in an action brought by a party shall be applicable in any arbitration proceeding, and the commencement of an arbitration proceeding shall be deemed the commencement of an action for these purposes. The Federal Arbitration Act shall apply to the construction, interpretation, and enforcement of this arbitration provision.

Caption Headings. Caption headings in this Deed of Trust are for convenience purposes only and are not to be used to interpret or define the provisions of this Deed of Trust.

Merger. There shall be no merger of the interest or estate created by this Deed of Trust with any other interest or estate in the Property at any time held by or for the benefit of Lender in any capacity, without the written consent of Lender.

Governing Law. This Deed of Trust will be governed by, construed and enforced in accordance with federal law and the laws of the State of Tennessee. This Deed of Trust has been accepted by Lender in the State of Tennessee.

No Waiver by Lender. Lender shall not be deemed to have waived any rights under this Deed of Trust unless such waiver is given in writing and signed by Lender. No delay or omission on the part of Lender in exercising any right shall operate as a waiver of such right or any other right. A waiver by Lender of a provision of this Deed of Trust shall not prejudice or constitute a waiver of Lender's right otherwise to demand strict compliance with that provision or any other provision of this Deed of Trust. No prior waiver by Lender, nor any course of dealing between Lender and Grantor, shall constitute a waiver of any of Lender's rights or of any of Grantor's obligations as to any future transactions. Whenever the consent of Lender is required under this Deed of Trust, the granting of such consent by Lender in any instance shall not constitute continuing consent to subsequent instances where such consent is required and in all cases such consent may be

to any circumstance, that finding shall not make the offending provision illegal, invalid, or unenforceable as to any other circumstance. If feasible, the offending provision shall be considered modified so that it becomes legal, valid and enforceable. If the offending provision cannot be so modified, it shall be considered deleted from this Deed of Trust. Unless otherwise required by law, the illegality, invalidity, or unenforceability of any provision of this Deed of Trust shall not affect the legality, validity or enforceability of any other provision of this Deed of Trust.

Successors and Assigns. Subject to any limitations stated in this Deed of Trust on transfer of Grantor's interest, this Deed of Trust shall be binding upon and inure to the benefit of the parties, their successors and assigns. If ownership of the Property becomes vested in a person other than Grantor, Lender, without notice to Grantor, may deal with Grantor's successors with reference to this Deed of Trust and the Indebtedness by way of forbearance or extension without releasing Grantor from the obligations of this Deed of Trust or liability under the Indebtedness.

Time is of the Essence. Time is of the essence in the performance of this Deed of Trust.

Waive Jury. All parties to this Deed of Trust hereby waive the right to any jury trial in any action, proceeding, or counterclaim brought by any party against any other party.

Miscellaneous Waivers. Grantor waives all right of homestead, equity of redemption, statutory right of redemption, and relinquishes all other rights and exemptions of every kind, including, but not limited to, a statutory right to an elective share in the Property.

DEFINITIONS. The following capitalized words and terms shall have the following meanings when used in this Deed of Trust. Unless specifically stated to the contrary, all references to dollar amounts shall mean amounts in lawful money of the United States of America. Words and terms used in the singular shall include the plural, and the plural shall include the singular, as the context may require. Words and terms not otherwise defined in this Deed of Trust shall have the meanings attributed to such terms in the Uniform Commercial Code:

Beneficiary. The word "Beneficiary" means Union Planters Bank, National Association, and its successors and assigns.

Borrower. The word "Borrower" means Joseph B. DeLozier III, PLLC, and all other persons and entities signing the Note in whatever capacity.

Deed of Trust. The words "Deed of Trust" mean this Deed of Trust among Grantor, Lender, and Trustee, and includes without limitation all assignment and security interest provisions relating to the Personal Property and Rents.

Default. The word "Default" means the Default set forth in this Deed of Trust in the section titled "Default".

Environmental Laws. The words "Environmental Laws" mean any and all state, federal and local statutes, regulations and ordinances relating to the protection of human health or the environment, including without limitation the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended, 42 U.S.C. Section 9601, et seq. ("CERCLA"), the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499 ("SARA"), the Hazardous Materials Transportation Act, 49 U.S.C. Section 1801, et seq., the Resource Conservation and Recovery Act, 42 U.S.C. Section 6901, et seq., the Hazardous Waste Management Substances Act of 1998, T.C.A., 68-212-201, et seq., or other applicable state or federal laws, rules, or regulations adopted pursuant thereto.

Event of Default. The words "Event of Default" mean any of the events of default set forth in this Deed of Trust in the events of default section of this Deed of Trust.

Grantor. The word "Grantor" means Joseph B. DeLozier III, PLLC.

Guarantor. The word "Guarantor" means any guarantor, surety, or accommodation party of any or all of the Indebtedness.

Guaranty. The word "Guaranty" means the guaranty from Guarantor to Lender, including without limitation a guaranty of all or part of the Note.

Hazardous Substances. The words "Hazardous Substances" mean materials that, because of their quantity, concentration or physical, chemical or infectious characteristics, may cause or pose a present or potential hazard to human health or the environment when improperly used, treated, stored, disposed of, generated, manufactured, transported or otherwise handled. The words "Hazardous Substances" are used in their very broadest sense and include without limitation any and all hazardous or toxic substances, materials or waste as defined by or listed under the Environmental Laws. The term "Hazardous Substances" also includes, without limitation, petroleum and petroleum by-products or any fraction thereof and asbestos.

Improvements. The word "Improvements" means all existing and future improvements, buildings, structures, mobile homes affixed on the Real Property, facilities, additions, replacements and other construction on the Real Property.

Indebtedness. The word "Indebtedness" means all principal, interest, and other amounts, costs and expenses payable under the Note or Related Documents, together with all renewals of, extensions of, modifications of, consolidations of and substitutions for the Note or Related Documents and any amounts expended or advanced by Lender to discharge Grantor's obligations or expenses incurred by Trustee or Lender to enforce Grantor's obligations under this Deed of Trust, together with interest on such amounts as provided in this Deed of Trust.

Lender. The word "Lender" means Union Planters Bank, National Association, its successors and assigns.

Note. The word "Note" means the promissory note dated February 20, 2001, **in the original principal amount of $750,000.00** from Grantor to Lender, together with all renewals of, extensions of, modifications of, refinancings of, consolidations of, and substitutions for the promissory note or agreement.

Personal Property. The words "Personal Property" mean all equipment, fixtures, and other articles of personal property now or hereafter owned by Grantor, and now or hereafter attached or affixed to the Real Property; together with all accessions, parts, and additions to, all replacements of, and all substitutions for, any of such property; and together with all proceeds (including without limitation all insurance proceeds and refunds of premiums) from any sale or other disposition of the Property.

Property. The word "Property" means collectively the Real Property and the Personal Property.

Real Property. The words "Real Property" mean the real property, interests and rights, as further described in this Deed of Trust.

Related Documents. The words "Related Documents" mean all promissory notes, credit agreements, loan agreements, environmental agreements, guaranties, security agreements, mortgages, deeds of trust, security deeds, collateral mortgages, and all other instruments, agreements and documents, whether now or hereafter existing, executed in connection with the Indebtedness.

Rents. The word "Rents" means all present and future rents, revenues, income, issues, royalties, profits, and other benefits derived from the Property.

Trustee. The word "Trustee" means Vaden Lackey, Jr., whose address is 424 Church Street, Suite 2800, Nashville, TN 37219 and any substitute or successor trustees.

GRANTOR ACKNOWLEDGES HAVING READ ALL THE PROVISIONS OF THIS DEED OF TRUST, AND GRANTOR AGREES TO ITS TERMS.

GRANTOR:

JOSEPH B. DELOZIER III, PLLC

By: _____
Joseph B. DeLozier III, Manager of Joseph B. DeLozier III, PLLC

LENDER:

UNION PLANTERS BANK, NATIONAL ASSOCIATION

X _____
Authorized Officer

LIMITED LIABILITY COMPANY ACKNOWLEDGMENT

STATE OF Tennessee)
) SS
COUNTY OF Davidson)

Before me, John M. Bomar, a Notary Public in and for State and County, personally appeared **Joseph B. DeLozier III, Manager of Joseph B. DeLozier III, PLLC** _____, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself or herself to be a member of **Joseph B. DeLozier III, PLLC** _____, the within–named bargainor, a Limited Liability Company, and that he or she as such member executed the foregoing instrument for the purposes therein contained, by signing the name of the Limited Liability Company by himself or herself as such member.

WITNESS my hand and seal at office, on the 2nd **day of** February, 20 02.

My Commission Expires: 3-23-02

Notary Public

LENDER ACKNOWLEDGMENT

STATE OF Tennessee)
) SS
COUNTY OF Davidson)

Before me, John M. Bomar, a Notary Public in and for the State and County aforesaid, personally appeared C. Eugene Angle with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself or herself to be the V.P. V.P. the within–named bargainor, a corporation, and that he or she as such _____, being duly authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself or herself as such V.P.

WITNESS my hand and seal at office, on the 2nd **day of** February, 20 02.

My Commission Expires: 3-23-02

Notary Public

Being a parcel of land in the First Civil District of Nashville, Davidson County, Tennessee, located on the westerly margin of Twenty-Third Avenue North being a portion of lots 123 and 124 as shown on Elliston's Plan of record in Plat Book 21, page 141, Register's Office for Davidson County, Tennessee, and being more particularly described as follows:

Beginning at an iron pin in the westerly margin of Twenty-Third Avenue North, said pin being northerly 246 feet along said margin from the northerly margin of Brandau Place;

Thence, leaving said margin with the north line of Lindsey Cooper, Sr. of record in Deed Book 10474, page 933, said Register's Office, S 54°43'10" W, 185.00 feet to an iron pin in the easterly margin of an alley;

Thence, with the easterly margin of said Alley, N 35°10'49" W, 55.00 feet to a point;

Thence, leaving said alley with the southerly line of Metro Government, N 54°43'10" E, 185.00 feet to an iron pin in the west margin of Twenty-Third Avenue North;

Thence, with said margin S 35°10'49" E, 55.00 feet to the point of beginning, containing 10,175 square feet or 0.23 acres, more or less.

Being the same property conveyed to Grantor by deed from Grace Development, Inc., of record as instrument number 20010320001562 7 Register's Office for Davidson County, Tennessee.

Unofficial Property Record Card - Davidson County - Nashville, TN

General Property Data

Parcel Identification 092 15 0 037.00

Property Owner JOSEPH B. DELOZIER, III, PLLC

Property Location 209 23RD AVE N NASHVILLE

Property Use COM

Mailing Address 209 23RD AVE N

Most Recent Sale Date 2/20/2001

Sale Price 500,000

City NASHVILLE

Legal Reference 20010220-0015627

Mailing State TN **Zip** 37203

Land Area 0.23 acres

Zone 2

Tax District USD

Current Property Appraisal

Fiscal Year 2011

Total Value 603,600

Land Value 254,400

Building Value 349,200

Building Description

Building Style OFFICE

Foundation Type TYPICAL

# of Living Units 1

Frame Type COM WD FR

Year Built 1910

Building Grade OFB

Roof Cover TYPICAL

Building Condition Average

Siding STUCCO

Finished Area (SF) 4956

Number Rooms 0

Number Beds 0

# of Full Baths 0

# of 3/4 Baths 0

# of 1/2 Baths 0

# of Total Fixtures 0

Legal Description

PT LOTS 123 & 124 ELLISTON

Narrative Description of Property

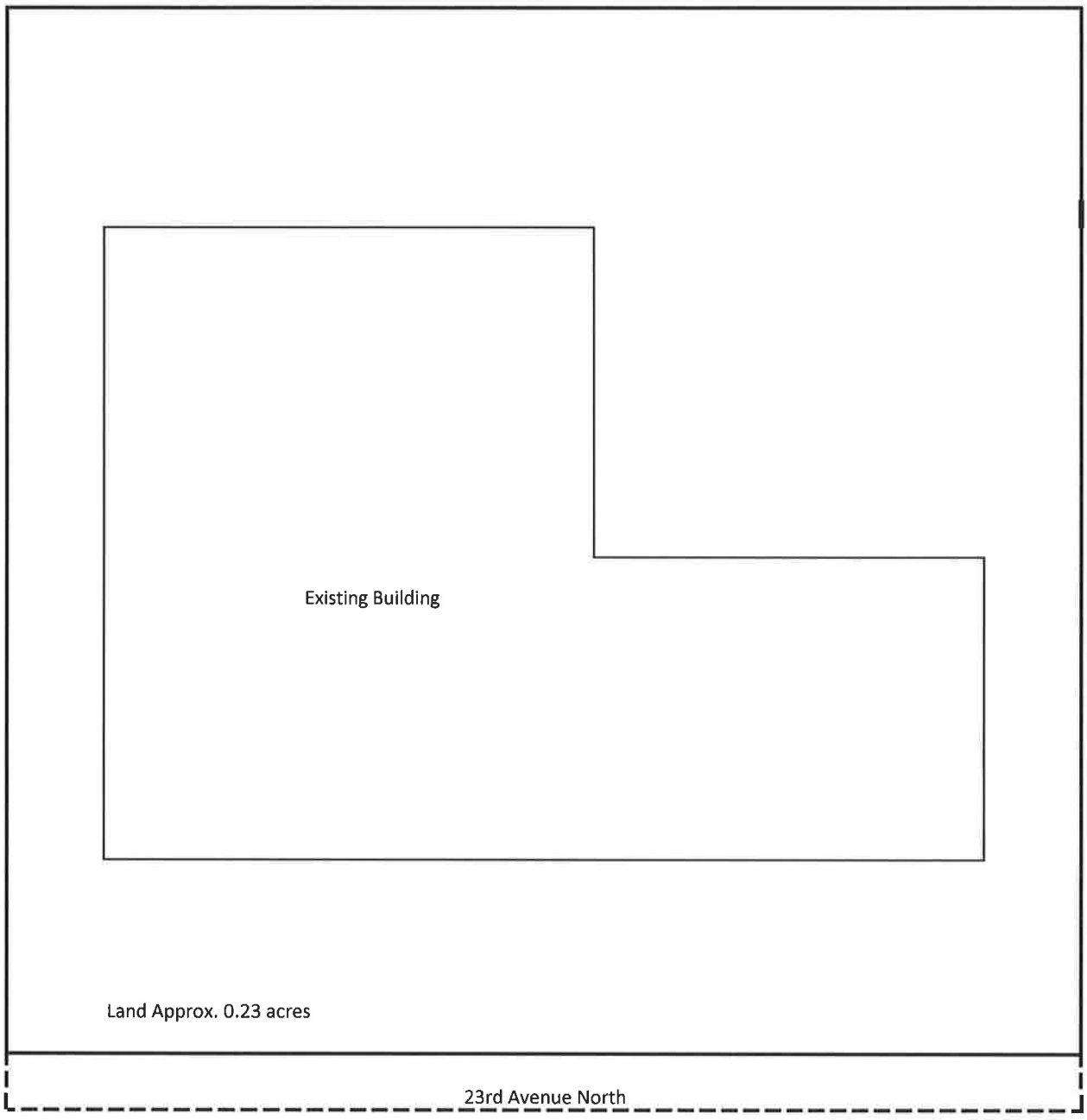
This property contains 0.23 acres of land mainly classified for assessment purposes* as COM with a(n) OFFICE style building, built about 1910 , having STUCCO exterior and TYPICAL roof cover, with 1 unit(s), 0 room(s), 0 bedroom(s), 0 bath(s), 0 half bath(s). *The classification for assessment purposes is not an zoning designation and does not speak to the legality of the current use of the subject property.

Property Images

Disclaimer: This information is believed to be correct but is subject to change and is not warranteed.

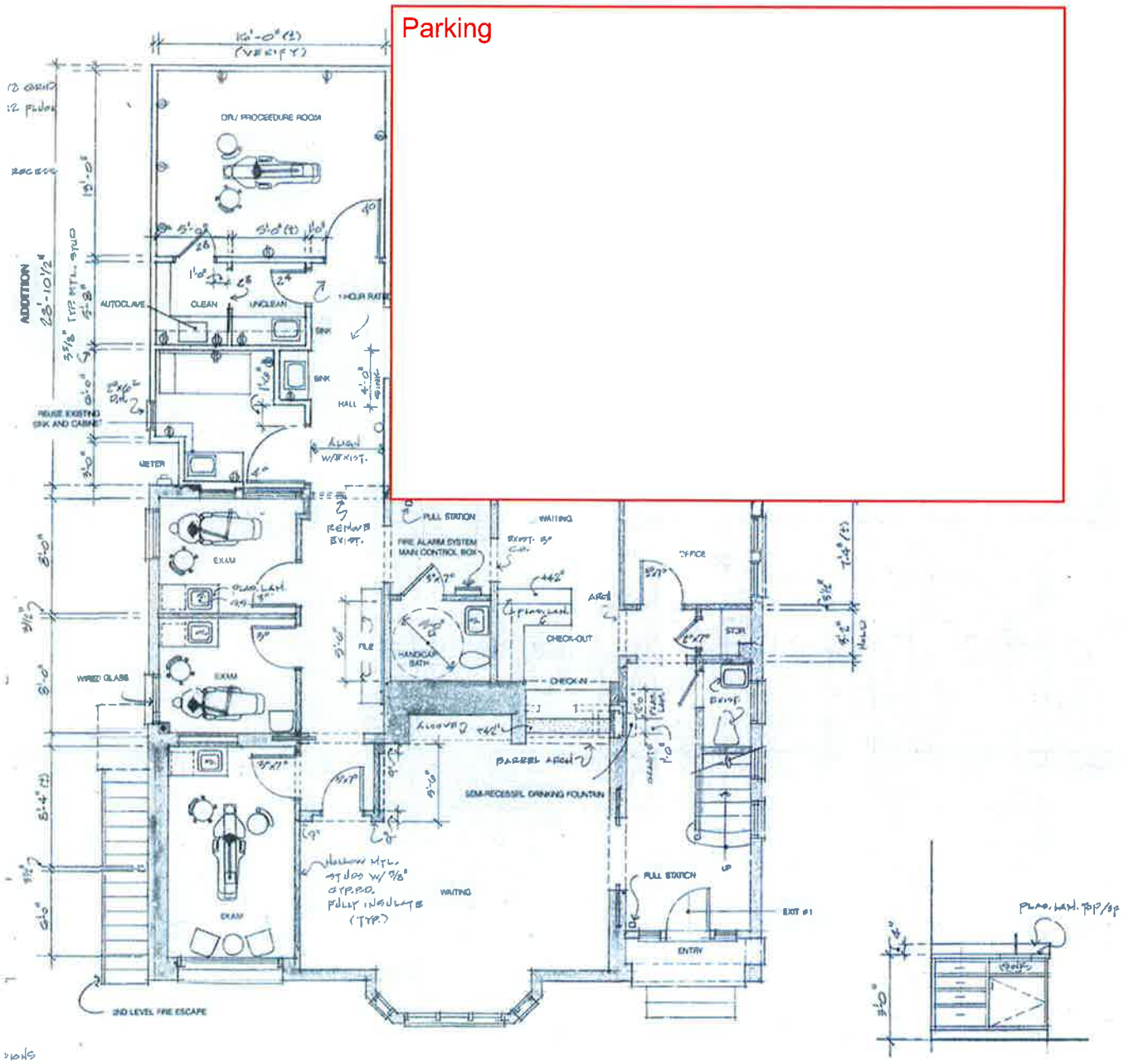
Attachment A-6B

Delozier Surgery Center
Attachment A-6B-1 - Plot Plan



Delozier Surgery Center
Floor Plan

Proposed addition in highlighted box indicated below.



Attachment B-A3

DeLozier Surgery Center
CON Application
Attachment B - A4

Specialty	2014	2015	2016	3-Year Average	2-Year Growth
Plastic Surgery	5,654	2,242	2,034	3,310	-64.03%
Pain Management	27,854	15,597	15,597	19,683	-44.00%
Podiatry	3,471	879	875	1,742	-74.79%

DeLozier Surgery Center
CON Application
Attachment B - A4

Center	County	Operating Rooms	Operating Room Cases	Procedure Rooms	Procedure Room Cases	Plastic Surgery Cases	Pain Management Cases	Podiatry Cases	Cases Per Operating Room	Cases Per Procedure Room
DeLozier Surgery Center	Davidson	1	449	0	0	449	0	0	449.00	
Baptist Ambulatory Surgery Center	Davidson	6	5,650	1	1,260	0	1,955	0	941.67	1,260.00
Baptist Plaza Surgicare	Davidson	9	8,487	1	1,011	814	1,160	0	943.00	1,011.00
Centennial Surgery Center	Davidson	6	5,216	2	2,315	132	784	95	869.33	1,157.50
Northridge Surgery Center	Davidson	5	201	2	1,916	13	221	313	40.20	958.00
Premier Radiology Pain Management Ctr.	Davidson	0	0	2	2,002	0	2,002	0		1,001.00
St. Thomas Surgicare	Davidson	6	5,973	1	1,317	291	1,322	74	995.50	1,317.00
Summit Surgery Center	Davidson	5	4,983	1	428	49	337	169	996.60	428.00
Tennessee Pain Surgery Center	Davidson	1	8,162	3	2,210	0	10,372	0	8,162.00	736.67
Cool Springs Surgery Center	Williamson	5	5,698	2	3,526	286	1,094	183	1,139.60	1,763.00
Crossroads Surgery Center	Williamson	0	0	2	748	0	748	0		374.00
Franklin Endoscopy Center	Williamson	2	1,283	2	3,449	0	1	41	641.50	1,724.50
Totals		46	46,102	19	20,182	2,034	19,996	875	1,002.22	1,062.21

DeLozier Surgery Center
CON Application
Attachment B - A4

Center	County	Operating Rooms	Operating Room Cases	Procedure Rooms	Procedure Room Cases	Plastic Surgery Cases	Pain Management Cases	Podiatry Cases	Cases Per Operating Room	Cases Per Procedure Room
DeLozier Surgery Center	Davidson	1	457	0	0	457	0	0	457.00	
Baptist Ambulatory Surgery Center	Davidson	6	5,723	1	1,829	0	1,829	0	953.83	1,829.00
Baptist Plaza Surgicare	Davidson	10	7,318	2	919	834	728	0	731.80	459.50
Centennial Surgery Center	Davidson	6	6,058	2	980	144	591	114	1,009.67	490.00
Nashville Surgery Center	Davidson	5	517	1	64	156	0	22	103.40	
Northridge Surgery Center	Davidson	5	1,766	2	538	16	241	339	353.20	269.00
Premier Radiology Pain Management Ctr.	Davidson	0	0	2	2,114	0	2,114	0		1,057.00
St. Thomas Surgicare	Davidson	6	5,963	1	1,240	304	1,245	89	993.83	1,240.00
Summit Surgery Center	Davidson	5	4,105	1	264	46	274	136	821.00	264.00
Tennessee Pain Surgery Center	Davidson	1	1,514	3	6,060	0	7,574	0	1,514.00	2,020.00
Cool Springs Surgery Center	Williamson	5	5,448	2	2,746	285	864	179	1,089.60	1,373.00
Crossroads Surgery Center	Williamson	0	0	2	137	0	137	0		68.50
Franklin Endoscopy Center	Williamson	2	1,028	2	2,975	0	0	0	514.00	1,487.50
Totals		52	39,897	21	19,866	2,242	15,597	879	767.25	946.00

DeLozier Surgery Center
CON Application
Attachment B - A4

Center	County	Operating Rooms	Procedure Rooms	Cases	Plastic Surgery Cases	Pain Management Cases	Podiatry Cases	Cases Per Procedure Room
DeLozier Surgery Center	Davidson	1	0	954	954	0	0	
Baptist Ambulatory Surgery Center	Davidson	6	1	20,054	0	2,892	3	2,864.86
Baptist Plaza Surgicare	Davidson	9	1	23,628	2,164	1,096	0	2,362.80
Centennial Surgery Center	Davidson	6	2	11,334	187	1,305	374	1,416.75
Nashville Surgery Center	Davidson	5	1	3,927	400	0	68	654.50
Northridge Surgery Center	Davidson	5	2	5,147	41	440	1,504	735.29
Premier Radiology Pain Management Ctr.	Davidson	0	2	2,087	0	2,087	0	1,043.50
St. Thomas Surgicare	Davidson	6	1	22,459	898	3,957	307	3,208.43
Summit Surgery Center	Davidson	5	1	12,890	153	1,154	572	2,148.33
Tennessee Pain Surgery Center	Davidson	1	3	8,169	0	8,169	0	2,042.25
Cool Springs Surgery Center	Williamson	5	2	22,257	857	2,681	643	3,179.57
Crossroads Surgery Center	Williamson	0	2	669	0	669	0	334.50
Franklin Endoscopy Center	Williamson	2	2	3,404	0	3,404	0	851.00
Totals		51	20	136,979	5,654	27,854	3,471	6,848.95

Attachment B-A9

American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

presents this certificate to

Delozier Surgical Center, PLLS

for having met the standards of a CLASS C ambulatory surgery facility in which major surgical procedures are performed under intravenous Propofol or general anesthesia with external support of vital organs.

AAAASF President
David C. Watts, MD

Secretary/Treasurer
Lawrence S. Reed, MD

Certified from 5/2/2017 to 5/2/2018

Certification Number 2616

Attachment B-B5

Pinnacle
FINANCIAL PARTNERS

November 6, 2017

State of Tennessee
Health Services and Development Agency
161 Rosa L Parks Blvd #3
Nashville, TN 37203

Dear Sirs:

After reviewing the financial records of the Delozier Surgery Center, it is without qualification that I can state that the company has more than adequate reserves. The company can fund the planned $50,000.00 investment in expanded services without undue stress on the ongoing performance of the practice.

If there are any further certifications that you might need, please feel free to contact me directly at 615-744-2920.

Sincerely,

Mike Blanchard
Senior Vice President

150 3rd Avenue South
Suite 900
Nashville, TN 37201
www.pnfp.com

Attachment B-D1

Board for Licensing Health Care Facilities

State of Tennessee

License No. 0000000165

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

DELOZIER SURGERY CENTER, LLC *to conduct and maintain*

an Ambulatory Surgical Treatment Center DELOZIER SURGERY CENTER, LLC

Located at 209 23RD AVENUE NORTH, NASHVILLE

County of DAVIDSON *, Tennessee.*

This license shall expire NOVEMBER 05 , 2018 , *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 12TH *day of* OCTOBER , 2017 .

In the Speciality(ies) of: PLASTIC SURGERY

By Vincent J. Davis, MPH

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By

COMMISSIONER

Attachment B-D2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES
WEST TENNESSEE REGIONAL OFFICE
2975 HIGHWAY 45 BYPASS, SUITE C
JACKSON, TENNESSEE 38305
PHONE: (731) 984-9684
FAX: (731) 512-0063

IMPORTANT NOTICE – PLEASE READ CAREFULLY

February 5, 2015

Joseph Delozier
Delozier Surgery Center, LLC
209 23rd Ave. North
Nashville, TN 37203

RE: CMS Certification # 44C0001156
Recertification Health Survey – 2/6/15

Dear Mr. Delozier:

Enclosed is the statement of deficiency developed as the result of the recertification health survey completed in your facility **February 3, 2015** by the West Tennessee Regional Office of Health Care Facilities. You are asked to submit an acceptable plan of correction to this office within **ten (10) days** from the date of this letter. The completion date for each deficiency should not be later than **45 days** from the last day of the survey.

During your recertification survey, **one** () **Standard Level** deficiencies were cited under the following number: **Q 181.**

Two (2) State Level deficiency was cited under the following number: **A 660, & A 1102.**

To be acceptable, a plan of correction must respond to each deficiency noted, stating specifically how each deficiency will be corrected and give the approximate date of completion. It is essential for purposes of clarification, as well as your best interest, that your plan of correction specify the exact measures which will be taken to correct each deficiency. As both the statements of deficiencies and plans of correction are subject to public disclosure, statements such as "will comply by", "will complete by", and "already corrected" will not be considered acceptable.

Your plan of correction must contain the following indicators:

- ✓ How the deficiency will be corrected;
- ✓ The date the deficiency will be corrected;
- ✓ What measures or systemic changes will be put in place to ensure that the deficient practice does not recur
- ✓ How the corrective action will be monitored to ensure that the deficient practice does not recur

The Plan of Correction must be submitted on the CMS 2567 form enclosed, dated, titled, and signed by the administrator or a representative before it is considered "acceptable". Whenever possible, please contain your plan of correction response to the form furnished to you. In the event you need additional space, please continue your response on your letterhead or plain stationery, typing in the name of your facility, address and other identifying information. You may fax your Plan of Correction to this office to accomplish the deadline at (731) 512-0063. **However, the signed, original POC should be mailed back to this office.**

If you have any questions concerning the statement of deficiencies, survey process, or completion of forms, please feel free to contact me.

Sincerely,

P. Diane Carter, PHNC2

P. Diane Carter, RN, LNCC
Public Health Nurse Consultant 2

PDC/ab

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44C0001156	A. BUILDING _____ B. WING _____	02/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELOZIER SURGERY CENTER, LLC	209 23RD AVENUE NORTH NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 181	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure all medications were labeled with the date they were opened and failed to date, time, and initial pre-drawn syringes for 1 of 2 (2/2/15) days of the recertification survey. The findings included: 1. Review of the facility's "Policy on Medication Labeling" policy documented, "...All open multi-dose medications will be labeled with the date on which they were opened..." Review of the facility's "Policy for medication vials" policy documented, ..."Date, time, and initial the vial when you use it. Syringes of medications drawn up for a case must be labeled in the same fashion..." 2. Observations in the procedure room on 2/2/15 at 11:00 AM, revealed a syringe laying on the anesthesia cart with a white substance in it which was not labeled, dated, timed or initialed. Observations in the procedure room on 2/2/15 at 11:00 AM, revealed a syringe laying on the anesthesia cart labeled "Lidocaine" but was not dated, timed or initialed.	Q 181	On 2/11/15, the day this letter was received, a meeting was held with both CRNAs who service this facility. They were counseled directly by Dr Delozier to label all medicines even if they were to be given immediately (as was the case here). They understand that they are to draw up the medicines, label, & then give them. As Dr Delozier is the only surgeon operating @ this facility, he will monitor this policy personally. If further violations occurs, he will report this and suspend the anesthetist.	2/1/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

2/17/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44C0001156	A. BUILDING _____ B. WING _____	02/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELOZIER SURGERY CENTER, LLC	209 23RD AVENUE NORTH NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 181	Continued From page 1 Observations in the procedure room on 2/2/15 at 11:20 AM, revealed a syringe laying on the anesthesia cart labeled "Midozolam" but not dated, timed or initialed. Observations in the procedure room on 2/2/15 at 2:35 PM, revealed a 50 milliliter vial of Lidocaine 1 percent on top of the anesthesia cart which was opened but not dated. Observations in the procedure room on 2/2/15 at 2:35 PM, revealed 2 insulin syringes with a clear substance in each one in a drawer on top of the anesthesia cart which were not labeled, dated or timed. Observations in the procedure room on 2/2/15 at 2:37 PM, revealed a bottle of nasal decongestant in the drawer of the anesthesia cart which was opened but not dated. 3. During an interview in the procedure room on 2/2/15 at 11:20 AM, when asked about the syringes not being labeled, dated, timed or initialed, the Certified Registered Nurse Anesthetist stated, "I draw my medicines up before each case." During an interview in the procedure room on 2/2/15 at 2:35 PM, the Director of Nursing verified the multi-dose vial of Lidocaine should have been dated and proceeded to discard it. During an interview in the procedure room on 2/2/15 at 2:35 PM, the Director of Nursing verified the insulin syringes should not have been in the drawer on top of the anesthesia cart with no label, date or time, and proceeded to discard these.	Q 181		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44C0001156	A. BUILDING _____ B. WING _____	02/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELOZIER SURGERY CENTER, LLC	209 23RD AVENUE NORTH NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 181	Continued From page 2 During an interview in the procedure room on 2/2/15 at 2:37 PM, the Director of Nursing stated, "That (nasal decongestant) is used for only 1 patient and should not be in there." The Director of Nursing proceeded to discard the nasal decongestant.	Q 181		

40

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP535165	A. BUILDING: _____ B. WING _____	02/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELOZIER SURGERY CENTER, LLC	209 23RD AVENUE NORTH NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 660	1200-8-10-.06 (2)(g) Basic Services (2) Anesthesiology Services. (g) When inhaled general anesthesia known to trigger malignant hyperthermia and/orsuccinylcholine are maintained in the facility, there shall be thirty-six (36) ampules of Dantrolene for injection onsite. This requirement applies to anesthesia agents, current or future, that are shown to cause malignant hyperthermia. If Dantrolene is administered, appropriate monitoring must be provided post-operatively. This Rule is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure thirty-six ampules of dantrolene for injection were maintained on site during 2 of 2 (2/2/15 and 2/3/15) days of the recertification survey. The findings included: 1. Review of the facility's "Emergency Therapy for Malignant Hyperthermia" policy documented, "...ACUTE PHASE TREATMENT...Administer dantrolene sodium 2-3 mg [milligrams]/kg [kilograms] initial bolus rapidly with increments up to 10 mg/kg total. Continue to administer dantrolene until signs of MH [malignant hyperthermia]...are controlled. Occasionally, at total dose greater than 10mg/kg may be needed. Each vial of dantrolene contains 20 mg of dantrolene..." 2. Observations in the procedure room on 2/2/15 at 2:50 PM, revealed 12 vials of dantrolene (total of 240 mg).	A 660	We have purchased and are storing the now-required amount of Dantrolene (36). This regulation had changed since our last review. We are now aware of it.	2/07/15

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP535165	A. BUILDING: _____ B. WING _____	02/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELOZIER SURGERY CENTER, LLC	209 23RD AVENUE NORTH NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 660	Continued From page 1 Observations in the 2nd floor medication refrigerator on 2/2/15 at 3:15 PM, revealed 11 vials of succinylcholine. 3. During an interview in the procedure room on 2/2/15 at 2:50 PM, the Director of Nursing (DON) confirmed the facility administered succinylcholine. The DON confirmed the facility had only 12 vials of dantrolene available onsite. During an interview in the conference room on 2/3/15 at 12:30 PM, the DON stated the facility did not have the required 36 vials of dantrolene onsite.	A 660		
A1102	1200-8-10-.11 (2) Records and Reports (2) The facility shall report information contained in the medical records of patients who have cancer or pre-cancerous or tumorous diseases as provided by existing regulations. These reports shall be sent to the Cancer Reporting System of the department on a quarterly schedule no later than six (6) months after the date of the diagnosis or treatment. This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to ensure quarterly reports for patients who have cancer or precancerous or tumorous diseases were sent to the Cancer Reporting System of the department. The findings included: During an interview in the conference room on 2/3/15 at 9:00 AM, when asked about sending the quarterly reports to the Cancer Reporting System of the department for patients who have cancer	A1102	- WE HAVE DISCUSSED WITH JERRY HARDEN & TERESA BUTLER & THE TN CANCER REGISTRY THE PROTOCOL FOR MONTHLY REPORTING OF CARCINOMAS. WE WILL BEGIN LOOKING AT PATH REPORTS, BEGINNING 4/1/13, AND SUBMIT A MONTHLY REPORT.	3/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP535165	A. BUILDING: _____ B. WING _____	02/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELOZIER SURGERY CENTER, LLC	209 23RD AVENUE NORTH NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1102	Continued From page 2 or precancerous or tumorous diseases, the Director of Nursing stated, "...we don't do those..."	A1102		

TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
227 FRENCH LANDING, SUITE 501
HERITAGE PLACE METROCENTER
NASHVILLE, TN 37243
TELEPHONE (615) 741-7221
FAX 615-741-7051
www.tennessee.gov/health

May 25, 2012

Kim Harvey Looney
Attorney
Waller Lansden Dortch & Davis, LLP
Nashville City Center
511 Union Street, Suite 2700
Nashville, TN 37219-8966

RE: Waiver Request: Square Footage of Operating Room – DeLozier Surgery Center, LLC.

Dear Ms. Looney:

The Board for Licensing Health Care Facilities met on May 2, 2012. The following request was granted:

TO ALLOW DELOZIER SURGERY CENTER TO WAIVE THE REQUIREMENT OF 400 SQUARE FEET OPERATING ROOMS USED TO PERFORM CLASS C PROCEDURES TO 250 SQUARE FEET IN ACCORDANCE WITH THEIR CERTIFICATE OF NEED WHICH IS LIMITED TO PLASTIC SURGERY.

Board action was taken in accordance with Section 68-11-209, Chapter 11, Tennessee Code Annotated, which gives the Board authority to waive rules and regulations that do not have a detrimental effect on the health, safety and welfare of the public.

If you have any questions you may contact this office at (615) 741-7221.

Sincerely,

Ann R. Reed

Ann Rutherford Reed, RN, BSN, MBA
Director of Licensure
Division of Health Care Facilities

ARR/weh

cc: Joseph B. Delozier, III
WTRO
File
Dee Ganaway

STATE OF TENNESSEE
Health Services and Development Agency

Certificate of Need No. **CN1108-028A** is hereby granted under the provisions of T.C.A. § 68-11-1601, *et seq.*, and rules and regulations issued thereunder by this Agency.

To: Joseph B. Delozier, III, M.D.
209 23rd Avenue North
Nashville, TN 37203

For: Delozier Surgery Center, LLC

This Certificate is issued for: The expansion of the existing single specialty ambulatory surgery treatment center (ASTC).

Limitations: 1. Single-specialty, limited to outpatient plastic and reconstructive surgery; and 2. Two (2) operating rooms.

On the premises located at: 209 23rd Avenue North
Nashville (Davidson County), TN 37203

For an estimated project cost of: $281,835.00

The Expiration Date for this Certificate of Need is

March 1, 2014

or upon completion of the action for which the Certificate of Need was granted, whichever occurs first. After the expiration date, this Certificate of Need is null and void.

Date Approved: January 25, 2012

Chairman

Date Issued: February 22, 2012

Executive Director

HF-0022 (Rev.1/04)

State of Tennessee
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES
WEST TENNESSEE REGIONAL OFFICE
2975 Highway 45 Bypass, Suite C
Jackson, Tennessee 38305-2873
Phone: (731) 984-9684
Fax: (731) 512-0063

April 26, 2012

Dr. Joseph Delozier, Administrator
Delozier Surgery Center, LLC
209 23rd Avenue North
Nashville, TN 37203

RE: Recertification Survey/Follow-Up
CCN 44C0001156

Dear Dr. Delozier:

The West Tennessee Regional Office of Health Care Facilities with the Tennessee Department of Health completed a recertification survey in your facility on **April 4-5, 2011**, to verify that your facility had achieved and maintained compliance with state and federal regulations. Based on a review of your plan of correction and onsite follow-up survey conducted 4/18/12, we are accepting your plan of correction and are assuming your facility is in compliance with all participation requirements. This office is recommending recertification in the Medicare and/or Medicaid program.

Thank you for your cooperation shown during the survey. If we may be of further assistance to you, please do not hesitate to call.

Sincerely,

P. Diane Carter, PHNC2

P. Diane Carter, RN, LNCC
Public Health Nurse Consultant 2

PDC/ab

American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

presents this certificate to

Delozier Surgical Center, PLLS

for having met the standards of a ***CLASS C*** *ambulatory surgery facility in which major surgical procedures are performed under intravenous Propofol or general anesthesia with external support of vital body functions.*

ABMS or Other Specialty: Plastic Surgery

AAAASF President *Harlan Pollock, M.D.*

Past President/ Treasurer *Lawrence S. Reed, M.D.*

The Gold Standard in Accreditation AASF

Certified from 05/02/2011 ***to*** 05/02/2012

Certification Number 2616

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975 C Highway 45 Bypass
JACKSON, TENNESSEE 38305

131-984- 9760 98384

IMPORTANT NOTICE – PLEASE READ CAREFULLY

February 19, 2015

Joseph Delozier
Delozier Surgery Center, LLC
209 23rd Ave. North
Nashville, TN 37203

It is "on her desk" – TB 2/23/15

RE: 2nd Request for Plan of Correction (POC) - Recertification Health Survey 2/3/15
CMS Certification # 44C0001156

Dear Mr. Delozier:

Enclosed is another statement of deficiencies cited as a result of the recertification health survey that was conducted on February 3, 2015 at your ASTC. A statement of deficiencies (SOD) was mailed to you on **February 5, 2015**. You were asked to submit an acceptable plan of correction for achieving compliance within (10) days from the date of the original letter (**February 15, 2015**). **To date our office has never received your plan of correction which is required to prevent termination of your facility from the ASTC program.**

Please address each deficiency separately with positive and specific statements advising this office of a plan of correction that includes acceptable time schedule, which will lead to the correction of the cited deficiencies. **The Plan of Correction must be submitted on the State Form enclosed**. ***Enter on the RIGHT SIDE OF THE STATE FORM, opposite the deficiencies, your planned action to correct the deficiencies and the expected completion date.*** The completion date can be no longer than 45 days from the day of survey. Before the plan can be considered "acceptable," ***it MUST BE SIGNED AND DATED by the administrator.***

During your recertification survey, **one (1) Standard Level** deficiencies were cited under the following number: **Q 181.**

Two (2) State Level deficiencies were cited under the following number: **A 660, & A 1102.**

Your plan of correction must contain the following:

- How the deficiency will be corrected;

- How the facility will prevent the same deficiency from recurring.
- The date the deficiency will be corrected;
- How the corrective action will be monitored to ensure that the deficient practice does not recur.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If assistance is needed, please feel free to call me at 731-984-9710.

Sincerely,

P. Diane Carter, RN, LNCC
Public Health Nurse Consultant II

PDC/ab

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44C0001156	A. BUILDING _____ B. WING _____	02/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELOZIER SURGERY CENTER, LLC	209 23RD AVENUE NORTH NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 181	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure all medications were labeled with the date they were opened and failed to date, time, and initial pre-drawn syringes for 1 of 2 (2/2/15) days of the recertification survey. The findings included: 1. Review of the facility's "Policy on Medication Labeling" policy documented, "...All open multi-dose medications will be labeled with the date on which they were opened..." Review of the facility's "Policy for medication vials" policy documented, ..."Date, time, and initial the vial when you use it. Syringes of medications drawn up for a case must be labeled in the same fashion..." 2. Observations in the procedure room on 2/2/15 at 11:00 AM, revealed a syringe laying on the anesthesia cart with a white substance in it which was not labeled, dated, timed or initialed. Observations in the procedure room on 2/2/15 at 11:00 AM, revealed a syringe laying on the anesthesia cart labeled "Lidocaine" but was not dated, timed or initialed.	Q 181		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A1102	1200-8-10-.11 (2) Records and Reports (2) The facility shall report information contained in the medical records of patients who have cancer or pre-cancerous or tumorous diseases as provided by existing regulations. These reports shall be sent to the Cancer Reporting System of the department on a quarterly schedule no later than six (6) months after the date of the diagnosis or treatment. This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to ensure quarterly reports for patients who have cancer or precancerous or tumorous diseases were sent to the Cancer Reporting System of the department. The findings included: During an interview in the conference room on 2/3/15 at 9:00 AM, when asked about sending the quarterly reports to the Cancer Reporting System of the department for patients who have cancer	A1102		

Division of Health Care Facilities

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STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES
WEST TENNESSEE REGIONAL OFFICE
2975 HIGHWAY 45 BYPASS, SUITE C
JACKSON, TENNESSEE 38305
PHONE: (731) 984-9684
FAX: (731) 512-0063

IMPORTANT NOTICE – PLEASE READ CAREFULLY

February 5, 2015

Joseph Delozier
Delozier Surgery Center, LLC
209 23rd Ave. North
Nashville, TN 37203

RE: CMS Certification # 44C0001156
Recertification Health Survey – 2/6/15

Dear Mr. Delozier:

Enclosed is the statement of deficiency developed as the result of the recertification health survey completed in your facility **February 3, 2015** by the West Tennessee Regional Office of Health Care Facilities. You are asked to submit an acceptable plan of correction to this office within **ten (10) days** from the date of this letter. The completion date for each deficiency should not be later than **45 days** from the last day of the survey.

During your recertification survey, **one () Standard Level** deficiencies were cited under the following number: **Q 181.**

Two (2) State Level deficiency was cited under the following number: **A 660, & A 1102.**

To be acceptable, a plan of correction must respond to each deficiency noted, stating specifically how each deficiency will be corrected and give the approximate date of completion. It is essential for purposes of clarification, as well as your best interest, that your plan of correction specify the exact measures which will be taken to correct each deficiency. As both the statements of deficiencies and plans of correction are subject to public disclosure, statements such as "will comply by", "will complete by", and "already corrected" will not be considered acceptable.

Your plan of correction must contain the following indicators:

- ✓ How the deficiency will be corrected;
- ✓ The date the deficiency will be corrected;
- ✓ What measures or systemic changes will be put in place to ensure that the deficient practice does not recur
- ✓ How the corrective action will be monitored to ensure that the deficient practice does not recur

The Plan of Correction must be submitted on the CMS 2567 form enclosed, dated, titled, and signed by the administrator or a representative before it is considered "acceptable". Whenever possible, please contain your plan of correction response to the form furnished to you. In the event you need additional space, please continue your response on your letterhead or plain stationery, typing in the name of your facility, address and other identifying information. You may fax your Plan of Correction to this office to accomplish the deadline at (731) 512-0063. **However, the signed, original POC should be mailed back to this office.**

If you have any questions concerning the statement of deficiencies, survey process, or completion of forms, please feel free to contact me.

Sincerely,

P. Diane Carter, PHNC2

P. Diane Carter, RN, LNCC
Public Health Nurse Consultant 2

PDC/ab

Enclosure

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Director 2/17/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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40

Division of Health Care Facilities

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AFFIDAVIT

RECEIVED
2017 NOV 13 AM 10:26
HEALTH SERVICES AND DEVELOPMENT AGENCY

STATE OF TENNESSEE

COUNTY OF WILLIAMSON

BRIAN WHITE, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. §68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE/TITLE

Sworn to and subscribed before me this 10TH day of NOVEMBER (Month), 2017 (Year) a Notary

Public in and for the County/State of WILLIAMSON / TENNESSEE.

NOTARY PUBLIC

My commission expires OCT 12 (Month/Day), 2019 (Year).

BRICE S. JONES
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY
MY COMMISSION EXPIRES OCT 12, 2019

HF-0004 Revised 12/2016 – All forms prior to this time are obsolete.


BRUCE S. JONES
NOTARY
PUBLIC

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

December 1, 2017

Mr. Brian White
Competitive Solutions, LLC
720 Cool Springs Blvd., Suite 470
Franklin, TN 37067

RE: Certificate of Need Application -- DeLozier Surgery Center - CN1711-032
The conversion of an existing single-specialty ambulatory surgical treatment center (ASTC) to a multi-specialty ASTC which is currently limited to plastic surgery procedures. The ASTC is located at 209 23rd Avenue North, Nashville (Davidson County), TN 37203. The service area consists of Davidson and Williamson Counties. The applicant is owned by DeLozier Surgery Center, LLC. The estimated project cost is $50,000.

Dear Mr. White:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1607, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on December 1, 2017. The first 60 days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review. You will receive a copy of their findings. The Health Services and Development Agency will review your application on February 28, 2018.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the The Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson (County), Tennessee, on or before November 10 (Month / day), 2017 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

DeLozier Surgery Center (Name of Applicant) ASTC (Facility Type-Existing)

owned by: DeLozier Surgery Center, LLC with an ownership type of LLC

and to be managed by: Owner intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

Conversion of an existing plastic surgery single specialty ASTC at 209 23rd Avenue North Nashville, TN 37203 to a multi-specialty ASTC. Project Cost is $50,000.

The anticipated date of filing the application is: November 15, 2017

The contact person for this project is Brian White (Contact Name) (Title)

who may be reached at: Competitive Solutions, LLC (Company Name) 720 Cool Springs Blvd. #470 (Address)

Franklin (City) TN (State) 37067 (Zip Code) 615 / 369-6336 x11 (Area Code / Phone Number)

(Signature) 11/8/2017 (Date) info@competitivesolutions.com (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

PUBLICATION OF INTENT

The following shall be published in the "Legal Notices" section of the newspaper in a space no smaller than two (2) columns by two (2) inches.

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

DeLozier Surgery Center (Name of Applicant), ASTC (Facility Type-Existing)

owned by: DeLozier Surgery Center, LLC with an ownership type of LLC

and to be managed by: Owner intends to file an application for a Certificate of Need

for [PROJECT DESCRIPTION BEGINS HERE]:

Conversion of an existing plastic surgery single specialty ASTC at 209 23rd Avenue N Nashville, TN 37203 to a multi-specialty ASTC. Project Cost is $50,000

The anticipated date of filing the application is: November 15, 20 17

The contact person for this project is Brian White (Contact Name), Consultant (Title)

who may be reached at: Competitive Solutions, LLC (Company Name), 720 Cool Springs Blvd. #470 (Address)

Franklin (City), TN (State), 37067 (Zip Code), 615 / 369-6336 x11 (Area Code / Phone Number)

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Supplemental #1

DeLozier Surgery Center

CN1711-032

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

November 22, 2017

Brian White
Competitive Solutions, LLC
720 Cool Springs Blvd., Suite 470
Franklin, TN 37203

RE: Certificate of Need Application CN1711-032
DeLozier Surgery Center

Dear Mr. White:

This will acknowledge our November 13, 2017 receipt of your application for a Certificate of Need to convert an existing single-specialty ambulatory surgical treatment center (ASTC), which is currently limited to plastic surgery procedures to a multi-specialty ASTC. The ASTC is located at 209 23rd Avenue North, Nashville (Davidson County), TN 37203.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 4:00 p.m., Monday, November 27, 2017. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

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1. **Section A, Applicant Profile, Item 1, Page 1**

   Please provide the web-site address for the DeLozier Surgery Center and submit a replacement page 1 (1R).

   Replacement Attached

2. **Section A, Executive Summary, Item 3.A. Page 2**

Please list each of the numbered points below individually (Description, Ownership Structure, Service Area, etc.) and provide a summary response underneath each point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

2) Ownership structure;

3) Service area;

4) Existing similar service providers;

5) Project cost;

6) Funding;

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

8) Staffing.

Replacement Attached

3. Section A, Executive Summary, Item 3.B.3 and 3.B.4 Page 3

It is noted the applicant is accredited by AAAASF as a Class C facility. Please briefly explain what AAAASF is and the significance of being accredited as a Class C facility.

Please replace "bed complement" with "operating rooms" in the bottom paragraph on page 3 and submit a replacement page.

Replacement Attached

4. Section A: Project Details, 4.B. Page 5

Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each

member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.

Replacement Attached

5. **Section A: Project Details, 6.B. (2) Page 7**

The floor plan is noted. Please indicate the square footage of the ASTC and existing operating room.

Replacement Attached

6. **Section A: Project Details, 6.B. (3) Page 7**

Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Replacement Attached

7. **Section A: Project Details, 9. Medicaid, Medicare Participation, Page 9**

It is noted the applicant will not participate in Medicaid/TennCare. However, since Medicaid/TennCare will reimburse for podiatry and pain management procedures, please discuss why the applicant chose not to participate in Medicaid/TennCare.

Replacement Attached

8. **Section A: Project Details, Item 10 Bed Complement Data, Page 10**

Since the applicant is not an inpatient facility, please provide a replacement page 10 reflecting no licensed beds.

Replacement Attached

9. **Section B, (Project Description) Item 1**

Please identify which hospitals that the surgeons expecting to use the ASTC have admitting privileges. Will all the surgeons expected to utilize the facility be able

to follow their patients in the case of an emergency transfer? (i.e.- admitting privileges at St. Thomas and Mid-Town).

The ASTC will require all participating physician/surgeons to have admitting privileges at St. Thomas Midtown enabling them to follow patients admitted in case of emergency.

10. Section C, Need Item 1 (Specific Criteria -ASTC) Item A.1. Page 14

Please indicate the projected number of OR cases in Year One and Year Two of the proposed project.

Quarter	*Projected Cases*
2018 Q1	*250*
2018 Q2	*250*
2018 Q3	*250*
2018 Q4	*250*
Total Year 1	*1000*
2019 Q1	*250*
2019 Q2	*250*
2019 Q3	*250*
2019 Q4	*250*
Total Year 2	*1000*

11. Section C, Need Item 1(Specific Criteria -ASTC) Item 2. Page 15

Please complete the following table for Year 2 of the proposed project

Operating Rooms	Procedures	Procedures/ Room	Minutes Used	Average Turnaround Time	Schedulable minutes*	% of Schedulable Time Used
Operating Room #1	*1,000*	*1,000*	*40,000*	*15 minutes*	*103,200*	*53%*

* defined as the summation of the minutes by each room available for scheduled cases Example: 7:30 AM to 4:30 PM, 5 days per week, 50 weeks/ year, equates to 9 hrs/day X 60 min/hr = 540 minutes/day X 5 days/week = 2,700 minutes / week X 50 weeks/year=135,000 schedulable minutes/room X the number of rooms=surgical suite schedulable capacity

12. Section C, Need Item 1(Specific Criteria –ASTC) Item 3. Page 15

Please complete the following table for the proposed service area ASTCs.

Multi-Specialty	2014	2015	2016	% Change from 15-16
Operating Rooms	49	50	44	-12%
Cases	125,769	37,926	37,491	-1%
Case Per OR	2,566.71	758.52	852.07	12%
Single-Specialty	2014	2015	2016	% Change from 15-16
Operating Rooms	2	2	2	0%
Cases	11,210	1,971	8,611	337%
Case Per OR	5,605	985.50	4,305.50	337%

Note, the 2014 JARS did not split the total cases into the Operating Room/Procedure Room buckets.

13. Section C, Need Item 1(Specific Criteria –ASTC) Item 4.

Please complete the following table for the proposed service area ASTCs.

Single Specialty ASTC Operating Room Utilization in the proposed Service Area

ASTC	County	#ORs	# Cases per OR	% of meeting Optimum Standard-884 per OR
DeLozier Surgery Center	Davidson	1	449	51%
Tennessee Pain Surgery Center	Davidson	1	8162	923%
TOTAL		**2**	**8611**	**485%**

Source: Tennessee Department of Health, Division of Health Statistics, 2016 Joint Annual Reports

Multi-Specialty ASTC Operating Room Utilization in the proposed Service Area

ASTC	County	# PRs	# Cases per OR	% of meeting Optimal Standard-884 per OR
Baptist Ambulatory Surgery Center	Davidson	6	941.67	107%
Baptist Plaza Surgicare	Davidson	9	943.00	107%
Centennial Surgery Center	Davidson	6	869.33	98%
Northridge Surgery Center	Davidson	5	40.20	5%
St. Thomas Surgicare	Davidson	6	995.50	113%
Summit Surgery Center	Davidson	5	996.60	113%
Cool Springs Surgery Center	Williamson	5	1139.60	129%
Franklin Endoscopy Center	Williamson	2	641.50	73%
TOTAL		**44**	**852.07**	**96%**

Source: Tennessee Department of Health, Division of Health Statistics, 2016 Joint Annual

14. Section B, Need Item 1(Specific Criteria –ASTC) Item 6. Page 17

It appears the applicant skipped #6 of the ASTC criterion. Please respond to the following question and provide a replacement page 17 (17R) incorporating the response into the revised page.

Access to ASTCs. The majority of the population in a Service Area should reside within 60 minutes average driving time to the facility.

The ASTC is located at 209 23rd Avenue N Nashville, TN 37203. The location is within 60 minutes average driving time of the entire service area, defined as Davidson and Williamson counties.

15. Section B, Need Item 1(Specific Criteria –ASTC) Item 11.c Page 19

Please clarify if the applicant plans to ever provide services to TennCare members, and if not, why?

The ASTC does not currently participate in TennCare programs. Original negotiations approximately 5 years ago broke down as reimbursement rates were not sufficient to cover the cost of plastic surgery cases in the ASTC. The ASTC is willing to negotiating a mutually acceptable contractual relationship with TennCare programs for podiatry and pain management.

16. Section B, Need Item C, Page 20

It is noted there has been a significant drop in plastic surgery, pain management and podiatry services provided in the ASTC setting against a growing population. If this is true, why is there a need to expand the applicant's ASTC when there is a diminishing need? Are patient's foregoing these procedures due to lack of available operating rooms, or is it due to decrease in demand?

Why is there a significant drop in plastic surgery, pain management and podiatry services provided in the ASTC setting against a growing population?

Lower revenue per procedure services like plastics, pain and podiatry are getting squeezed out by higher revenue procedures like orthopedics, ophthalmology and neurosurgery. Those higher revenue procedures are also seeing increases in the percentage of cases moving from inpatient to outpatient environments.

Reimbursement per case in orthopedics, ophthalmology and neurosurgery are significantly higher than cases in plastic surgery, pain management and podiatry. The high reimbursement specialty cases also often include reimbursement for devices, implants etc. that further enhance the typical per hour reimbursement.

These differences in reimbursement encourage multi-specialty ASTCs to emphasize and work diligently to attract more cases in those high reimbursement specialties and de-emphasize or 'squeeze-out' the lower reimbursement specialties. The case volume of plastic surgery, pain management and podiatry exhibit that shift in case volume.

17. Section B, Need Item E, Page 23

Please provide utilization for each of the most recent three years of data available using the table below.

Note: The 2014 totals in Joint Annual Reports do not break out cases into the operating room and procedure room buckets.

2 County Service Area ASTC Patient Utilization 2014-2016

County	Single Specialty ASTC	2014		2015		2016		% Change 15-16
		# of Operating Rooms	# Operating Rooms Cases	# of Operating Rooms	# Operating Rooms Cases	# of Operating Rooms	# Operating Rooms Cases	
Davidson	DeLozier Surgery Center	1	954	1	457	1	449	-2%
Davidson	Tennessee Pain Surgery Center	1	8169	1	1514	1	8162	439%
Service Area	**Single-Specialty Subtotal**	2	9123	2	1971	2	8611	337%
	Multi-specialty ASTCs							
Davidson	Baptist Ambulatory Surgery Center	6	20054	6	5723	6	5650	-1%
Davidson	Baptist Plaza Surgicare	9	23628	10	7318	9	8487	16%
Davidson	Centennial Surgery Center	6	11334	6	6058	6	5216	-14%
Davidson	Nashville Surgery Center	5	3927	5	517	0	0	-100%
Davidson	Northridge Surgery Center	5	5147	5	1766	5	201	-89%
Davidson	St. Thomas Surgicare	6	22459	5	5963	6	5973	0%
Davidson	Summit Surgery Center	5	12890	6	4105	5	4983	21%
Williamson	Cool Springs Surgery Center	5	22257	5	5448	5	5698	5%
Williamson	Franklin Endoscopy Center	2	3404	5	1028	2	1283	25%
Service Area	**Multi-specialty ASTCs Subtotal**	49	125100	50	37926	44	37491	-1%
	Grand Total	51	134223	52	39897	46	46102	16%

Please complete the following table by ASTC for each specialty (podiatry, pain management, and plastic surgery) for 2014-2016.

Podiatry					
ASTC	County	2014 Cases	2015 Cases	2016 Cases	% Change 14-16
Baptist Ambulatory Surgery Center	Davidson	3	0	0	-100%
Centennial Surgery Center	Davidson	374	114	95	-75%
Nashville Surgery Center	Davidson	68	22	0	-100%
Northridge Surgery Center	Davidson	1504	339	313	-79%
St. Thomas Surgicare	Davidson	307	89	74	-76%
Summit Surgery Center	Davidson	572	136	169	-70%
Cool Springs Surgery Center	Williamson	643	179	183	-72%
Franklin Endoscopy Center	Williamson	0	0	41	~
Subtotal		3471	879	875	-75%
Pain Management					
Baptist Ambulatory Surgery Center	Davidson	2892	1829	1955	-32%
Baptist Plaza Surgicare	Davidson	1096	728	1160	6%
Centennial Surgery Center	Davidson	1305	591	784	-40%
Nashville Surgery Center	Davidson	0	0	0	~
Northridge Surgery Center	Davidson	440	241	221	-50%
Premier Radiology Pain Management Center	Davidson	2087	2114	2002	-4%
St. Thomas Surgicare	Davidson	3957	1245	1322	-67%
Summit Surgery Center	Davidson	1154	274	337	-71%
Tennessee Pain Surgery Center	Davidson	8169	7574	10372	27%
Cool Springs Surgery Center	Williamson	2681	864	1094	-59%
Crossroads Surgery Center	Williamson	669	137	748	12%
Franklin Endoscopy Center	Williamson	3404	0	1	-99%
Subtotal		27854	15597	19996	-28%
Plastic Surgery					
Baptist Plaza Surgicare	Davidson	2164	834	814	-72%
Centennial Surgery Center	Davidson	187	144	132	-29%
Nashville Surgery Center	Davidson	400	156	0	-100%
Northridge Surgery Center	Davidson	41	16	13	-68%
St. Thomas Surgicare	Davidson	898	304	291	-68%
Summit Surgery Center	Davidson	153	46	49	-68%
Cool Springs Surgery Center	Williamson	857	285	286	-67%
DeLozier Surgery Center	Davidson	954	457	449	-53%
Subtotal		5654	2242	2034	-74%
Grand Total		36979	18718	22905	-38%

Supplemental #1
November 27, 2017
11:59 am

Hospitals now report outpatient surgical cases by specialty beginning with 2016 JAR. Please complete the following table by reporting the two-county service area hospital surgery utilization for plastic surgery, pain management, and podiatry.

Podiatry		
Hospital	County	2016 Cases
Metropolitan Nashville General Hospital	Davidson	0
St. Thomas Midtown	Davidson	0
St. Thomas West	Davidson	197
Centennial Medical Center	Davidson	98
Skyline Medical Center	Davidson	20
Southern Hills Medical Center	Davidson	128
Summit Medical Center	Davidson	9
Vanderbilt Medical Center	Davidson	0
Williamson Medical Center	Williamson	0
Subtotal		452
Pain Management		
Metropolitan Nashville General Hospital	Davidson	0
St. Thomas Midtown	Davidson	1
St. Thomas West	Davidson	8
Centennial Medical Center	Davidson	160
Skyline Medical Center	Davidson	33
Southern Hills Medical Center	Davidson	15
Summit Medical Center	Davidson	4
Vanderbilt Medical Center	Davidson	0
Williamson Medical Center	Williamson	8
Subtotal		229
Plastic Surgery		
Metropolitan Nashville General Hospital	Davidson	6
St. Thomas Midtown	Davidson	376
St. Thomas West	Davidson	297
Centennial Medical Center	Davidson	2088
Skyline Medical Center	Davidson	318
Southern Hills Medical Center	Davidson	0
Summit Medical Center	Davidson	61
Vanderbilt Medical Center	Davidson	1889
Williamson Medical Center	Williamson	6
Subtotal		5041
Grand Total		5722

18. Section B, Need Item F, Page 23

Please provide surgical case projections by specialty using the table below:

Specialty	# of Surgeons	Year 1 OR Cases	Year 2 OR Cases
Podiatry	1	100	100
Plastic Surgery	1	450	450
Pain Mgmt.	1	450	450
Total	**3**	**1000**	**1000**

Since the applicant is requesting to be a multi-specialty ASTC, are there future plans to expand into other specialties?

At this time the ASTC does not have plans to expand into other specialties. The operating room is limited space and could potentially accommodate other non-equipment intensive specialties. However, to date no consideration has been given to additional specialties and the ASTC believes this change as planned will ultimately make near maximum use of the operating room.

19. Section B, Economic Feasibility, Item B. (Funding) Page 26

Please provide a letter from the Chief Financial Officer of the organization's intent to use cash reserves to fund the proposed project.

Attached.

20. Section B, Economic Feasibility, Item C. (Historical Data Chart) Page 27

Please indicate the type of utilization (cases, patients, etc.) data in Line A. in the Historical Data Chart and submit a replacement page 27.

The Historical Data Chart shows no Provision for Charity Care. Please explain.

Charity Care is performed by Dr. DeLozier and generally relate to pediatric cranio-facial patients who are more appropriately treated in a hospital setting. Those cases are taken on a case by case basis. The ASTC accounts on a Cash Basis, those Charity Care cases generate no revenue and thus are not included in the financials of the company.

It is noted the 2016 Joint Annual Report for the applicant reflected $12,533 in Bad Debt. Please clarify the reason no provision for bad debt was included in the Historical Data Chart.

Supplemental #1
November 27, 2017
11:59 am

The ASTC accounts on a Cash Basis, Bad Debt generates no revenue and thus is not included in the financials of the company.

There appears to be a slight calculation error in the 2015 Total Non-Operating Expenses column. Please correct and submit a replacement Historical Data Chart (27R).

Corrected and Attached.

21. Section B. Economic Feasibility Item D (Projected Data Chart) Page 30

The Projected Data Chart shows no Provision for Charity Care or Provision for Bad Debt. Please explain.

The ASTC accounts on a Cash Basis, Charity Care and Bad Debt generate no revenue and thus is not included in the financials of the company.

Please indicate the type of utilization (cases, patients, etc.) data in Line A. in the Projected Data Chart and submit a replacement page 30.

Attached.

22. Section B. Economic Feasibility Item E.3 Page 32

Please compare the proposed charges to those of similar facilities in the service area/adjoining service area, or to proposed charges of projects recently approved by the Health Services and Development Agency.

Below is a comparison of the Gross Charges of the proposed ASTC against the three geographically closest multi-specialty ASTCs:

ASTC	Gross Charges 2016	Cases 2016	Average Charge 2016
DeLozier Surgery Center (Proposed)	$2,000,000.00	1,000	$ 2,000.00
Centennial Surgery Center	$94,280,358.00	7,531	$ 12,518.97
Baptist Plaza Surgicare	$97,411,748.00	8,769	$ 11,108.65
Baptist Ambulatory Surgery Center	$66,494,087.00	7,610	$ 8,737.72

The nature of the limited specialty approach proposed creates a much lower Average Gross Charge.

23. Section B. Economic Feasibility Item F. Page 32

Please provide copies of DeLozier Surgery Center's balance sheet and income statement from the most recent reporting period and the most recent audited financial statements with accompanying notes, if applicable.

Balance Sheet and Income Statement to 10/31/2017 attached. DeLozier Surgery Center, LLC financials are not audited.

24. Section B. Contribution to Orderly Development Item C.D Page 36

The May 25, 2012 letter from the Department of Health waiving the requirement of 400 square feet operating rooms used to perform Class C procedures to 250 square feet limited to plastic surgery is noted. However, since the applicant is proposing to add podiatry and pain management procedures will this waiver be extended to those two specialties by the Tennessee Department of Health? Please discuss.

DeLozier Surgery Center intends to extend the current Class C waiver if this Certificate of Need proposal is approved. The specialties proposed are non-equipment intensive specialties. The current square footage can accommodate the necessary portable C-arm that may be required for some podiatry and pain management procedures. The ASTC does not intend to seek more heavy equipment dependent specialties as the current square footage would not accommodate many of those larger pieces of equipment.

A brief, informal discussion with the Tennessee Department of Health suggested that the plan as proposed would not face significant opposition to extending the waiver to podiatry and pain management as long as the equipment involved would not be an impediment to patient safety in the operating room. Applicant believes the plans as proposed will justify that waiver.

25. Section B, Orderly Development, Item D.2, Page 36

Please provide a letter from the Tennessee Department of Health that all deficiencies/findings have been corrected as a result of the recertification health survey that was conducted on February 5, 2015.

Attached.

24. Section B. Quality Measures

Please verify and acknowledge the applicant will be evaluated annually whether the proposal will provide health care that meets appropriate quality standards upon the following factors:

(a) Whether the applicant commits to maintaining an actual payor mix that is comparable to the payor mix projected in its CON application, particularly as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent;

Applicant commits to maintaining the proposed payer mix, continue the current efforts to accommodate Charity Care and Medically Indigent patients and, if approved, intends to revisit negotiations with TennCare with regard to podiatry and pain management services.

(b) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;

Applicant commits to maintaining staffing consistent with the staffing chart presented in this application.

(c) Whether the applicant will obtain and maintain all applicable state licenses in good standing;

Applicant commits to maintaining all applicable state licenses in good standing.

(d) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

Applicant commits to maintaining its Medicare certification and if agreements with TennCare are secured in the future will maintain TennCare certification as well.

(e) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;

Applicant is an existing ASTC and has maintained compliance with applicable state and federal regulations for the past three years.

(f) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

Applicant is an existing ASTC that has not been decertified.

(g) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

Applicant does, and will continue to, participate in AAAASF accreditation in effort of self-assessment and external peer assessment to pursue continuous improvement in all processes and operations.

(h) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

1. This may include accreditation by any organization approved by Centers for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor, for example, would be acceptable if applicable. Other acceptable accrediting organizations may include, but are not limited to, the following:

(ii) Accreditation Association for Ambulatory Health Care, and where applicable, American Association for Accreditation of Ambulatory Surgical Facilities, for Ambulatory Surgical Treatment Center projects.

Applicant does, and will continue to, participate in AAAASF accreditation in effort of self-assessment and external peer assessment to pursue continuous improvement in all processes and operations.

(i) For Ambulatory Surgical Treatment Center projects, whether the applicant has estimated the number of physicians by specialty expected to utilize the facility, developed criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel, and documented the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

Applicant does, and will continue to, maintain developed criteria to evaluate and extend surgical and anesthesia privileges to medical personnel. Applicant documents staff qualifications for medical and ancillary services.

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In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is January 19, 2018. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ə 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip Earhart
HSD Examiner

Enc.

Supplemental #1
November 27, 2017
11:59 am

State of Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution

DeLozier Surgery Center
Name

209 23rd Avenue North — Davidson
Street or Route — County

Nashville — TN — 37203
City — State — Zip Code

Website address: None

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

2. Contact Person Available for Responses to Questions

Brian White
Name — Title

Competitive Solutions, LLC — info@competitivesolutions.com
Company Name — Email address

720 Cool Springs Blvd. Suite 470 — Franklin — TN — 37067
Street or Route — City — State — Zip Code

Consultant — 615.369.6336 x11 — 615.369.6336
Association with Owner — Phone Number — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable).* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

DeLozier Surgery Center intends to convert the current single specialty plastic surgery ASTC with 1 operating room to a multi-specialty ASTC with no increase in the bed complement.

2) Ownership structure;

The ownership structure will remain the same with DeLozier Surgery Center, LLC owning 100% of the ASTC and controlled by its sole member, Dr. Joseph B. DeLozier, III, MD.

3) Service area;

The ASTC will continue to service Davidson and Williamson counties with approximately 85% of the centers business derived from those two counties. No other county accounts for more than 5% of the projected case volume. The additional specialties served by the ASTC will be pain management and podiatry.

4) Existing similar service providers;

The market is currently served by 9 multi-specialty ASTCs open to all market providers and 2 ASTCs dedicated to pain management limited to the owner practices. The multi-specialty ASTCs currently restrict access to pain management and podiatry in favor of more profitable lines of service including orthopedic surgery, ophthalmology and GI. Plastic surgery, pain management and podiatry have seen significant reductions in case volume in the existing centers over the past three years.

5) Project cost;

The Project Cost is estimated to be $50,000

6) Funding;

The Project will be funded by the current owners of the center from operating income and cash reserves.

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

Because the plan will not expand the physical plant of the ASTC, the project requires very little investment and is financially feasible as it will increase the revenue of the ASTC with little to no fixed cost associated with the expansion. The project will add to the financial margin almost immediately.

8) Staffing.

The ASTC's new services will be staffed with pain management physicians and podiatrists currently working in the market and current ancillary staff will expand their work hours to accommodate the new volume. Some PRN additional labor may be required and the ASTC currently has a pool of ancillary staff that works on an as needed basis.

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B. of this application. Please summarize in one page or less each of the criteria:

1) Need;

Currently the corporate partnership model surgery centers are squeezing out pain management and podiatry for higher revenue procedures in orthopedics, ophthalmology and neurosurgery. The existing pain management centers are owned by specific pain management service providers and not reasonably accessible to providers not employed by those groups. The expansion will provide greater access to patients, expand the available options for surgical treatment of pain management and podiatry patients.

2) Economic Feasibility;

The addition of these services will require minimal investment in equipment, reducing the cost of entry. The expansion of services will allow DeLozier Surgery Center to expand the use of existing infrastructure generating greater access for patients and immediate revenue expansion at limited increase in fixed cost.

3) Appropriate Quality Standards; and

DeLozier Surgery Center currently participates in Medicare certification programs as well as AAAASF accreditation programs and will expand those quality programs to the new service lines offered.

The American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF) was established in 1980 to standardize and improve the quality of health care in outpatient facilities. AAAASF accredits thousands of facilities world-wide, making it one of the largest not-for-profit outpatient accrediting organizations.

AAAASF accreditation programs help facilities demonstrate a strong commitment to patient safety, standardize quality, maintain fiscal responsibility, promote services to patients and collaborate with other health care leaders.

AAAASF provides official recognition to facilities that have met 100% of its high standards. Accreditation assures the public that patient safety is top priority in a facility.

An accredited facility must comply with the most stringent set of applicable standards available in the nation and meet our strict requirements for facility director, medical specialist certification and staff credentials. It also must pass a thorough survey by qualified AAAASF surveyors.

An accredited facility is re-evaluated through a self-survey every year, and an onsite survey every three years. Facilities must continuously comply with all AAAASF accreditation standards between surveys. Upon approval, an accredited facility must prominently display its accreditation certificate in public view.

An accredited facility must be fully equipped to perform procedures in the medical specialties listed on its accreditation application.

4) Orderly Development to adequate and effective health care.

This conversion to multi-specialty ASTC from single specialty ASTC designation will not change the overall operating rooms in the market, will improve access to care for pain management and podiatry patients in a ASTC that is already fully credentialed and compliant with local, state and federal regulations. The ASTC will serve patients across all demographic groups in Davidson and Williamson counties.

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4. SECTION A: PROJECT DETAILS

A. Owner of the Facility, Agency or Institution

DeLozier Surgery Center, LLC		615.565.9000
Name		Phone Number
209 23rd Avenue North		Davidson
Street or Route		County
Nashville	TN	37203
City	State	Zip Code

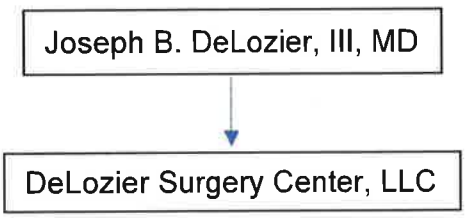
B. Type of Ownership of Control (Check One)

A.	Sole Proprietorship _____	F.	Government (State of TN or _____ Political Subdivision)
B.	Partnership _____		
C.	Limited Partnership _____	G.	Joint Venture _____
D.	Corporation (For Profit) _____	H.	Limited Liability Company X
E.	Corporation (Not-for-Profit) _____	I.	Other (Specify)_____ _____

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx. **Attachment Section A-4A.**

Describe *the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.*

DeLozier Surgery Center, LLC is a single member LLC wholly (100%) owned by Joseph B. DeLozier, III, MD



6A. Legal Interest in the Site of the Institution (Check One)

1) Ownership __X__
2) Option to Purchase _____
3) Lease of _____ Years _____
D. Option to Lease _____
E. Other (Specify) _____ _____

Check appropriate line above: *For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

6B. Attach **a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site** on an 8 1/2" x 11" sheet of white paper, single or double-sided. ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

4) Plot Plan **must include**:
   a. Size of site (***in acres***);
   b. Location of structure on the site;
   c. Location of the proposed construction/renovation; and
   d. Names of streets, roads or highway that cross or border the site.

5) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8 ½ by 11 sheet of paper or as many as necessary to illustrate the floor plan.

The ASTC encompasses 514 sq.ft. The existing Operating Room encompasses 258 sq.ft. compliant under the waiver for a plastic surgery operating room and will additionally meet the standard for podiatry and pain management.

6) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Metro Davidson County bus lines have stops within a half mile of the 23rd Avenue location on Charlotte Avenue and Elliston Place. There is no public transportation stop on 23rd Avenue between Charlotte Avenue and Elliston Place.

Attachment Section A-6A, 6B-1 a-d, 6B-2, 6B-3.

7. Type of Institution (Check as appropriate--more than one response may apply)

A. Hospital (Specify)_____ _____
B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty X
C. ASTC, Single Specialty _____
D. Home Health Agency _____
E. Hospice _____
F. Mental Health Hospital _____
G. Intellectual Disability Institutional Habilitation Facility ICF/IID _____
H. Nursing Home _____
I. Outpatient Diagnostic Center _____
J. Rehabilitation Facility _____
K. Residential Hospice _____
L. Nonresidential Substitution-Based Treatment Center for Opiate Addiction _____
M. Other (Specify)_____ _____

Check appropriate lines(s).

8. Purpose of Review (Check appropriate lines(s) – more than one response may apply)

A. New Institution _____
B. Modifying an ASTC with limitation still required per CON X
C. Addition of MRI Unit _____
D. Pediatric MRI _____
E. Initiation of Health Care Service as defined in T.C.A. §68-11-1607(4) _____
(Specify)_____
F. Change in Bed Complement _____
[Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]
G. Satellite Emergency Dept. _____
H. Change of Location _____
I. Other (Specify)_____ _____

9. Medicaid/TennCare, Medicare Participation

MCO Contracts [Check all that apply]

___AmeriGroup ___United Healthcare Community Plan ___BlueCare ___TennCare Select

Medicare Provider Number ___3089369_____

Medicaid Provider Number _____

Certification Type _____

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare __Yes __No __N/A Medicaid/TennCare __Yes __No __N/A

The ASTC does not currently participate in TennCare programs. Original negotiations approximately 5 years ago broke down as reimbursement rates were not sufficient to cover the cost of plastic surgery cases in the ASTC. The ASTC is open to negotiating with TennCare programs for podiatry and pain management.

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10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.

		Current Licensed	*Beds Staffed*	*Beds Proposed*	**Beds Approved*	***Beds Exempted*	*TOTAL Beds at Completion*
1)	Medical						
2)	Surgical						
3)	ICU/CCU						
4)	Obstetrical						
5)	NICU						
6)	Pediatric						
7)	Adult Psychiatric						
8)	Geriatric Psychiatric						
9)	Child/Adolescent Psychiatric						
10)	Rehabilitation						
11)	Adult Chemical Dependency						
12)	Child/Adolescent Chemical Dependency						
13)	Long-Term Care Hospital						
14)	Swing Beds						
15)	Nursing Home – SNF (Medicare only)						
16)	Nursing Home – NF (Medicaid only)						
17)	Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18)	Nursing Home – Licensed (non-certified)						
19)	ICF/IID						
20)	Residential Hospice						
	TOTAL						

**Beds approved but not yet in service* ***Beds exempted under 10% per 3 year provision*

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. **Attachment Section A-10.**

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.

CON Number(s)	CON Expiration Date	Total Licensed Beds Approved

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X Total Facility
☐ Project Only

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

		Year 2014	Year 2015	Year 2016
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits)	954 Cases	457 Cases	449 Cases
B.	Revenue from Services to Patients			
1.	Inpatient Services	$	$	$
2.	Outpatient Services	1,121,275	1,160,928	879,144
3.	Emergency Services			
4.	Other Operating Revenue (Specify)_____			
	Gross Operating Revenue	$ 1,121,275	$ 1,160,928	$879,144
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$527,645	$ 516,782	$ 332,381
2.	Provision for Charity Care			
3.	Provisions for Bad Debt			
	Total Deductions	$ 527,645	$ 516,782	$332,381
NET OPERATING REVENUE		$ 593,630	$ 644,146	$546,763
D.	Operating Expenses			
1.	Salaries and Wages			
	a. Direct Patient Care	363,600	380,000	380,000
	b. Non-Patient Care			
2.	Physician's Salaries and Wages			
3.	Supplies	82,300	74,300	82,900
4.	Rent			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates			
5.	Management Fees:			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates			
6.	Other Operating Expenses			
	Total Operating Expenses	$ 445,900	$ 454,300	$462,900
E.	**Earnings Before Interest, Taxes and Depreciation**	$ 147,730	$ 189,846	$ 83,863
F.	Non-Operating Expenses			
1.	Taxes	$	$	$
2.	Depreciation	14,100	17,200	15,800
3.	Interest			
4.	Other Non-Operating Expenses	9,400	13,200	15,400
	Total Non-Operating Expenses	$ 23,500	$ 30,400	$ 31,200
NET INCOME (LOSS)		$ 124,230	$ 159,446	$52,663

Chart Continues Onto Next Page

NET INCOME (LOSS)	$ 124,230	$ 159,446	$ 52,663
G. Other Deductions			
1. Annual Principal Debt Repayment	$	$	$
2. Annual Capital Expenditure			
Total Other Deductions	$ 0	$ 0	$ 0
NET BALANCE	$ 124,230	$ 159,446	$ 52,663
DEPRECIATION	$ 14,100	$ 17,200	$ 15,800
FREE CASH FLOW (Net Balance + Depreciation)	$ 138,330	$ 176,646	$ 68,463

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X Total Facility

☐ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

	OTHER EXPENSES CATEGORIES	Year 2014	Year 2015	*Year 2016*
1.	Professional Services Contract	$ 0	$ 0	$ 0
2.	Contract Labor	0	0	0
3.	Imaging Interpretation Fees	0	0	0
4.				
5.				
6.				
7.				
	Total Other Expenses	$ 0	$ 0	$ 0

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☒ Total Facility
☐ Project Only

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 2018	Year 2019
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits)	1000 Cases	1000 Cases
B.	Revenue from Services to Patients		
1.	Inpatient Services		
2.	Outpatient Services	2,000,000	2,000,000
3.	Emergency Services		
4.	Other Operating Revenue (Specify)_____		
	Gross Operating Revenue	$ 2,000,000	$ 2,000,000
C	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$ 900,000	$ 900,000
2.	Provision for Charity Care		
3.	Provisions for Bad Debt		
	Total Deductions	$900,000	$ 900,000
NET OPERATING REVENUE		$1,100,000	$1,100,000
D.	Operating Expenses		
1.	Salaries and Wages		
	a. Direct Patient Care	650,000	650,000
	b. Non-Patient Care		
2.	Physician's Salaries and Wages		
3.	Supplies	110,000	110,0000
4.	Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates		
5.	Management Fees:		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates		
	c. Other Operating Expenses		
	Total Operating Expenses	$ 760,000	$ 760,000
E.	**Earnings Before Interest, Taxes and Depreciation**	$ 340,000	$ 340,000
F.	Non-Operating Expenses		
1.	Taxes	$	$
2.	Depreciation	18,000	18,000
3.	Interest		
4.	Other Non-Operating Expenses	15,000	15,000
	Total Non-Operating Expenses	$ 33,000	$ 33,000
	NET INCOME (LOSS)	$ 307,000	$ 307,000

Chart Continues Onto Next Page

Supplemental #1
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NET INCOME (LOSS)		$ 307,000	$ 307,000
G.	Other Deductions		
1.	Estimated Annual Principal Debt Repayment	$ 0	$ 0
2.	Annual Capital Expenditure	0	0
	Total Other Deductions	$ 0	$ 0
	NET BALANCE	$ 307,000	$ 307,000
	DEPRECIATION	$ 18,000	$ 18,000
	FREE CASH FLOW (Net Balance + Depreciation)	$ 325,000	$ 325,000

X Total Facility

☐ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

	OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1.	Professional Services Contract	$	$
2.	Contract Labor		
3.	Imaging Interpretation Fees		
4.			
5.			
6.			
7.			
	Total Other Expenses	**$ 0**	**$ 0**

Supplemental #1
November 27, 2017
11:59 am

DeLozier Surgery Center
209 23rd Avenue North
Nashville, Tennessee 37203

State of Tennessee
Health Services and Development Agency

Tuesday, November 21, 2017

Dear Sir or Madam:

DeLozier Surgery Center intends to use cash reserves to fund the proposed change from a single specialty ambulatory surgery center to a multi-specialty ambulatory surgery center. The company has sufficient funds to cover the planned $50,000 investment.

If you have further questions, please feel free to contact me directly.

Sincerely,

Joseph B. DeLozier, III, MD
Owner

DeLozier Surgery Center, LLC

Balance Sheet

October 31, 2017

Year to Date

Supplemental #1

November 27, 2017

11:59 am

Assets		
Cash	$	165,328
Total Assets	$	165,328
Liabilities & Equity		
Retained Earnings	$	(65,212)
Net Income	$	230,540
Total Liabilities & Equity	$	165,328

DeLozier Surgery Center, LLC

Income Statement

October 31, 2017

Year to Date

Supplemental #1

November 27, 2017

11:59 am

Total Revenue	$	727,403
Operating Expenses		
Salaries & Wages	$	236,706
CC Discount	$	10,319
Cylinder Gas Expense	$	2,454
Lab & Testing	$	5,518
Implant Expense	$	123,270
Pharmaceuticals	$	9,739
Laundry Expense	$	9,111
	$	93,983
Maintenance & Repairs	$	3,958
Taxes & Licenses	$	1,805
Total Operating Expenses	$	496,863
Net Income	$	230,540

Cash Basis

Supplemental #1
November 27, 2017
11:59 am

RECEIVED 2017 NOV 27 11:59

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF WILLIAMSON

R BRIAN WHITE, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. §68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE/TITLE

Sworn to and subscribed before me this 22ND day of NOVEMBER (Month), 2017 (Year) a Notary Public in and for the County/State of WILLIAMSON/TENNESSEE.

NOTARY PUBLIC

My commission expires OCT 12 (Month/Day), 2019 (Year).

BRICE S. JONES
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY
MY COMMISSION EXPIRES OCT 12, 2019

Supplemental #1
November 27, 2017
11:59 am

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES
WEST TENNESSEE REGIONAL OFFICE
2975 Highway 45 Bypass
Jackson, Tennessee 38305-2873
Phone: (731) 984-9684

March 11, 2015

Joseph Delozier
Delozier Surgery Center, LLC
209 23rd Avenue N.
Nashville, TN 37203

RE: Recertification Survey – 2/3/15

Dear Mr. Delozier:

The Department of Health West TN Regional Office of Health Care Facilities completed an annual recertification survey of your facility on **February 3, 2015.** Based on a desk review completed on **March 10, 2015**, we are accepting your plan of correction and assume your facility is in compliance with all participation requirements.

If this office may be of any assistance to you, please do not hesitate to call.

Sincerely,

P. Diane Carter, PHNC2

P. Diane Carter, RN, LNCC
Public Health Nurse Consultant 2

PDC/ab

Supplemental #A2

DeLozier Surgery Center

CN1711-032

Supplemental #A2
November 30, 2017
10:54 am

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

November 29, 2017

Brian White
Competitive Solutions, LLC
720 Cool Springs Blvd., Suite 470
Franklin, TN 37203

RE: Certificate of Need Application CN1711-032
DeLozier Surgery Center

Dear Mr. White:

This will acknowledge our November 27, 2017 receipt of your supplemental response to convert an existing single-specialty ambulatory surgical treatment center (ASTC), which is currently limited to plastic surgery procedures to a multi-specialty ASTC. The ASTC is located at 209 23rd Avenue North, Nashville (Davidson County), TN 37203.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 4:00 p.m., Thursday, November 30, 2017. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

Please note that if additional information is added to the original application as a result of the supplemental request, please label additional pages as 1A, 1B, etc. to correspond with the original application page order. Also, please submit the supplemental response single-sided so that replacement pages may be incorporated into the original application.

1. **Section A, Applicant Profile, Item 1, Page 1**

   The applicant notes there is not a web-site address for the DeLozier Surgery Center. However, it appears the web-site for DeLozier Surgery Center is http://drdelozier.com/. Please clarify and submit a replacement page 1 (labeled as 1R) if necessary.

www.drdelozier.com is the website for Joseph B. DeLozier, III, MD, PLLC. Dr. DeLozier's private medical practice a separate entity from DeLozier Surgery Center with common ownership.

Attached

2. Section A, Executive Summary, Item 3.A. Page 2

It is noted the applicant listed each of the numbered points below individually (Description, Ownership Structure, Service Area, etc.) and provided a summary response underneath each point. However, please provide replacement pages that flow with the application with the appropriate page number (i.e.-1R, 2R. etc.)

1) Description - Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

2) Ownership structure;

3) Service area;

4) Existing similar service providers;

5) Project cost;

6) Funding;

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

8) Staffing.

Attached

3. Section A, Executive Summary, Item 3.B.3 and 3.B.4 Page 3

It is noted the applicant is accredited by AAAASF as a Class C facility and explained the significance of being accredited as a Class C facility. However, the applicant incorporated the response into what appears to be replacement page 4. Please provide a response to the question below without incorporating into the application.

Response to above question here:

DeLozier Surgery Center currently participates in Medicare certification programs as well as AAAASF accreditation programs and will expand those quality programs to the new service lines offered.

The American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF) was established in 1980 to standardize and improve the quality of health care in outpatient facilities. AAAASF accredits thousands of facilities world-wide, making it one of the largest not-for-profit outpatient accrediting organizations.

AAAASF accreditation programs help facilities demonstrate a strong commitment to patient safety, standardize quality, maintain fiscal responsibility, promote services to patients and collaborate with other health care leaders.

AAAASF provides official recognition to facilities that have met 100% of its high standards. Accreditation assures the public that patient safety is top priority in a facility.

An accredited facility must comply with the most stringent set of applicable standards available in the nation and meet our strict requirements for facility directors, medical specialist certification and staff credentials. It also must pass a thorough survey by qualified AAAASF surveyors.

An accredited facility is re-evaluated through a self-survey every year, and an onsite survey every three years. Facilities must continuously comply with all AAAASF accreditation standards between surveys. Upon approval, an accredited facility must prominently display its accreditation certificate in public view.

An accredited facility must be fully equipped to perform procedures in the medical specialties listed on its accreditation application.

It is noted the applicant replaced the "bed complement" with "operating rooms" that was located in the original application in the bottom paragraph on page 3. However, the replacement page was labeled as page 5 rather than page 3. **Please correct and submit a replacement page 3 (labeled as 3R).**

Attached

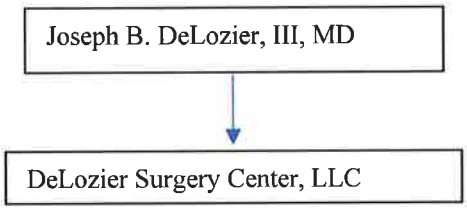
4. **Section A: Project Details, 4.B. Page 5**

It is noted the applicant described the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. It is also noted the applicant explained the corporate structure and the manner in which

all entities of the ownership structure relate to the applicant identifying the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest. However, please provide a response below rather than incorporating the response into page 7.

Response to above question here:

DeLozier Surgery Center, LLC is a single member LLC wholly (100%) owned by Joseph B. DeLozier, III, MD



5. **Section A: Project Details, 6.B. (2) Page 7**

   The floor plan is noted. Please indicate the square footage of the ASTC and existing operating room.

   Response to above question here:

The ASTC encompasses 514 sq.ft. The existing Operating Room encompasses 258 sq.ft. compliant under the waiver for a plastic surgery operating room and will additionally meet the standard for podiatry and pain management.

6. **Section A: Project Details, 6.B. (3) Page 7**

   Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

   Response to the above question here:

Metro Davidson County bus lines have stops within a half mile of the 23rd Avenue location on Charlotte Avenue and Elliston Place. There is no public transportation stop on 23rd Avenue between Charlotte Avenue and Elliston Place.

7. **Section A: Project Details, 9. Medicaid, Medicare Participation, Page 9**

   It is noted the applicant will not participate in Medicaid/TennCare. However, since Medicaid/TennCare will reimburse for podiatry and pain management procedures, please discuss why the applicant chose not to participate in Medicaid/TennCare.

   Response to the above question here:

   The ASTC does not currently participate in TennCare programs. Original negotiations approximately 5 years ago broke down as reimbursement rates were not sufficient to cover the cost of plastic surgery cases in the ASTC. The ASTC is open to negotiating with TennCare programs for podiatry and pain management.

8. **Section A: Project Details, Item 10 Bed Complement Data, Page 10**

   It is noted the applicant provided a replacement page 10 reflecting no licensed beds. However, please correctly label the page as 10R rather than page 14 and submit.

   Attached

9. **Section C, Need Item 1(Specific Criteria –ASTC) Item 2. Page 15**

   It is noted the applicant completed the following table for Year 2 of the proposed project. However, please provide calculations on how the applicant derived the applicant will use 53% of schedulable time in Year 2. How did the applicant figure there will be 103,200 schedulable minutes? Please clarify.

Operating Rooms	Procedures	Procedures/ Room	Minutes Used	Average Turnaround Time	Schedulable minutes*	% of Schedulable Time Used
Operating Room #1	1,000	1,000	40,000	15 minutes	65,000	48%

* defined as the summation of the minutes by each room available for scheduled cases Example: 7:30 AM to 4:30 PM, 5 days per week, 50 weeks/ year, equates to 9 hrs/day X 60 min/hr = 540 minutes/day X 5 days/week = 2,700 minutes / week X 50 weeks/year=135,000 schedulable minutes/room X the number of rooms=surgical suite schedulable capacity

10. **Section C, Need Item 1(Specific Criteria –ASTC) Item 3. Page 15**

    It is noted the applicant completed the following table for the proposed service area ASTCs. However, the figures provided for 2014 do not match the figures

the applicant provided for question #17 for the 2014-2016 ASTC utilization for the 2 county service area. For your convenience, the total from question #17 is provided below. Please clarify.

Multi-Specialty	2014	2015	2016	% Change from 14-16
Operating Rooms	**49**			
Cases	**125,100**			
Case Per OR	**2555**			
Single-Specialty	**2014**	2015	2016	% Change from 14-16
Operating Rooms	**2**			
Cases	**9,123**			
Case Per OR	**4,561**			

11. Section C, Need Item 1(Specific Criteria –ASTC) Item 4.

The following table for the proposed service area multi-specialty ASTCs is noted. However, there appears to be an error for the figures reported for Northridge Surgery Center. Please correct and revise the following table.

For this table, we used the 2016 data from JARs. Nashville Surgery Center had closed its 5 operating rooms. Baptist Plaza Surgicare had dropped from 10 operating rooms to 9 operating rooms.

Multi-Specialty ASTC Operating Room Utilization in the proposed Service Area

ASTC	County	# ORs	# Cases per OR	% of meeting Optimal Standard-884 per OR
Baptist Ambulatory Surgery Center	Davidson	6	941.67	107%
Baptist Plaza Surgicare	Davidson	9	943.00	107%
Centennial Surgery Center	Davidson	6	869.33	98%
Northridge Surgery Center	Davidson	5	434.20	49%
St. Thomas Surgicare	Davidson	6	995.50	113%
Summit Surgery Center	Davidson	5	996.60	113%
Cool Springs Surgery Center	Williamson	5	1139.60	129%
Franklin Endoscopy Center	Williamson	2	641.50	73%
TOTAL		**44**	**896.84**	**101%**

Source: Tennessee Department of Health, Division of Health Statistics, 2016 Joint Annual

12. Section B, Need Item C, Page 20

The applicant notes there has been a significant drop in plastic surgery, pain management and podiatry services provided in the ASTC setting against a growing population. However, there appears to be significant increases in the volume of pain management and plastic surgery ASTC cases from 2015 to 2016 as reported in the Joint Annual Reports. How does the significant actual **increases** in the JARs in the those areas support the assumption by the applicant there has been a significant **drop** in plastic surgery, pain management and podiatry services provided in the ASTC setting?

When the data includes both Operating Rooms and Procedure Rooms, the case volume shows significant drops in the volume of each:

Specialty	2014 Cases	2015 Cases	2016 Cases	3-Year Average	2-Year Growth
Plastic Surgery	5,654	2,242	2,034	3,310	-64.03%
Pain Management	27,854	15,597	15,597	19,683	-44.00%
Podiatry	3,471	879	875	1,742	-74.79%

This data shows the 'squeezing out' of those cases from ASTCs. Parsing the data to only the operating rooms (for which 2014 data did not split), the 2015 to 2016 trend is an increase but appears to not be representative of the true market shift when 2014 data is included.

Those cases did not vanish in an area of population growth. Cosmetic Plastic Surgery cases have been moved to office based operating rooms (non-CON). Pain Management cases have moved to more oral pain medication (opioids) as access to facilities to perform longer relief procedures including epidural steroid injections and nerve root blocks. Podiatry cases have been limited to in-office procedures that can be shorter term remedies causing repeated procedures.

13. Section B, Need Item E, Page 23

The table below of the utilization for each of the most recent three years of available data is noted. However, there is a calculation error in the # 2015 multi-specialty operating rooms. It appears there are 53 rather than 50. Please clarify and provide a corrected table below.

The Franklin Endoscopy # of Operating Rooms for 2015 was a typo, should be 2 operating rooms, not 5. Corrected below.

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2 County Service Area ASTC Patient Utilization 2014-2016

County	Single Specialty ASTC	2014		2015		2016		% Change 14-16
		# of Operating Rooms	# Operating Rooms Cases	# of Operating Rooms	# Operating Rooms Cases	# of Operating Rooms	# Operating Rooms Cases	
Davidson	DeLozier Surgery Center	1	954	1	457	1	449	-2%
Davidson	Tennessee Pain Surgery Center	1	8169	1	1514	1	8162	439%
Service Area	**Single-Specialty Subtotal**	2	9123	2	1971	2	8611	337%
	Multi-specialty ASTCs							
Davidson	Baptist Ambulatory Surgery Center	6	20054	6	5723	6	5650	-1%
Davidson	Baptist Plaza Surgicare	9	23628	10	7318	9	8487	16%
Davidson	Centennial Surgery Center	6	11334	6	6058	6	5216	-14%
Davidson	Nashville Surgery Center	5	3927	5	517	0	0	-100%
Davidson	Northridge Surgery Center	5	5147	5	1766	5	201	-89%
Davidson	St. Thomas Surgicare	6	22459	5	5963	6	5973	0%
Davidson	Summit Surgery Center	5	12890	6	4105	5	4983	21%
Williamson	Cool Springs Surgery Center	5	22257	5	5448	5	5698	5%
Williamson	Franklin Endoscopy Center	2	3404	2	1028	2	1283	25%
Service Area	**Multi-specialty ASTCs Subtotal**	49	125100	50	37926	44	37491	-1%
	Grand Total	51	134223	52	39897	46	46102	16%

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It is noted Centennial Medical Center and Vanderbilt Medical Center combined provided 3,977 outpatient plastic surgery cases in 2016. If this project is approved, how will it impact the future plastic surgery utilization of Centennial Medical Center and Vanderbilt Medical Center?

Plastic Surgery cases will not be impacted by this project as Dr. DeLozier will continue to be the only plastic surgeon using the facility and his patterns will not change. He does fewer than 5 pediatric cranio-facial cases annually at Vanderbilt Medical Center, that quantity will not be impacted. He does not perform cases at Centennial Medical Center currently.

14. Section B, Economic Feasibility, Item C. (Historical Data Chart) Page 27

It is noted the applicant provided a revised Historical Data Chart. However, the applicant labeled the chart as page 31 rather than the requested 27. Please submit the Historical Data Chart labeled as 27R and 28R (second page of the chart).

Attached

15. Section B. Economic Feasibility Item D (Projected Data Chart) Page 30

It is noted the applicant provided a revised Projected Data Chart. However, the applicant labeled the Projected Data Chart as page 34 rather than the requested page 30. Please submit a Projected Data Chart labeled as 30R and 31R (second page of the Projected Data Chart).

Attached

16. Section B. Economic Feasibility Item F (Projected Data Chart) Page 32

The DeLozier Surgery Center, LLC income statement is noted. However, please clarify the designation of $93,983 in the income statement that is unassigned.

Anesthesia Fees label corrected version attached.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is January 19, 2018. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the

review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɔ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip Earhart
HSD Examiner

Enc.

State of Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution

DeLozier Surgery Center
Name

209 23rd Avenue North — Davidson
Street or Route — County

Nashville — TN — 37203
City — State — Zip Code

Website address: www.drdelozier.com

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

2. Contact Person Available for Responses to Questions

Brian White
Name — Title

Competitive Solutions, LLC — info@competitivesolutions.com
Company Name — Email address

720 Cool Springs Blvd. Suite 470 — Franklin — TN — 37067
Street or Route — City — State — Zip Code

Consultant — 615.369.6336 x11 — 615.369.6336
Association with Owner — Phone Number — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable).* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

DeLozier Surgery Center intends to convert the current single specialty plastic surgery ASTC with 1 operating room to a multi-specialty ASTC with no increase in the bed complement.

2) Ownership structure;

The ownership structure will remain the same with DeLozier Surgery Center, LLC owning 100% of the ASTC and controlled by its sole member, Dr. Joseph B. DeLozier, III, MD.

3) Service area;

The ASTC will continue to service Davidson and Williamson counties with approximately 85% of the centers business derived from those two counties. No other county accounts for more than 5% of the projected case volume. The additional specialties served by the ASTC will be pain management and podiatry.

4) Existing similar service providers;

The market is currently served by 9 multi-specialty ASTCs open to all market providers and 2 ASTCs dedicated to pain management limited to the owner practices. The multi-specialty ASTCs currently restrict access to pain management and podiatry in favor of more profitable lines of service including orthopedic surgery, ophthalmology and GI. Plastic surgery, pain management and podiatry have seen significant reductions in case volume in the existing centers over the past three years.

5) Project cost;

The Project Cost is estimated to be $50,000

6) Funding;

The Project will be funded by the current owners of the center from operating income and cash reserves.

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

Because the plan will not expand the physical plant of the ASTC, the project requires very little investment and is financially feasible as it will increase the revenue of the ASTC with little to no fixed cost associated with the expansion. The project will add to the financial margin almost immediately.

8) Staffing.

The ASTC's new services will be staffed with pain management physicians and podiatrists currently working in the market and current ancillary staff will expand their work hours to accommodate the new volume. Some PRN additional labor may be required and the ASTC currently has a pool of ancillary staff that works on an as needed basis.

4) Orderly Development to adequate and effective health care.

This conversion to multi-specialty ASTC from single specialty ASTC designation will not change the overall operating rooms in the market, will improve access to care for pain management and podiatry patients in a ASTC that is already fully credentialed and compliant with local, state and federal regulations. The ASTC will serve patients across all demographic groups in Davidson and Williamson counties.

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10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.

		Current Licensed	*Beds Staffed*	*Beds Proposed*	**Beds Approved*	***Beds Exempted*	*TOTAL Beds at Completion*
1)	Medical						
2)	Surgical						
3)	ICU/CCU						
4)	Obstetrical						
5)	NICU						
6)	Pediatric						
7)	Adult Psychiatric						
8)	Geriatric Psychiatric						
9)	Child/Adolescent Psychiatric						
10)	Rehabilitation						
11)	Adult Chemical Dependency						
12)	Child/Adolescent Chemical Dependency						
13)	Long-Term Care Hospital						
14)	Swing Beds						
15)	Nursing Home – SNF (Medicare only)						
16)	Nursing Home – NF (Medicaid only)						
17)	Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18)	Nursing Home – Licensed (non-certified)						
19)	ICF/IID						
20)	Residential Hospice						
TOTAL							

**Beds approved but not yet in service* ***Beds exempted under 10% per 3 year provision*

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. **Attachment Section A-10.**

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.

CON Number(s)	CON Expiration Date	Total Licensed Beds Approved

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X Total Facility
□ Project Only

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

		Year 2014	Year 2015	Year 2016
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits)	954 Cases	457 Cases	449 Cases
B.	Revenue from Services to Patients			
1.	Inpatient Services	$	$	$
2.	Outpatient Services	1,121,275	1,160,928	879,144
3.	Emergency Services			
4.	Other Operating Revenue (Specify)_____			
	Gross Operating Revenue	$ 1,121,275	$ 1,160,928	$879,144
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$527,645	$ 516,782	$ 332,381
2.	Provision for Charity Care			
3.	Provisions for Bad Debt			
	Total Deductions	$ 527,645	$ 516,782	$332,381
NET OPERATING REVENUE		$ 593,630	$ 644,146	$546,763
D.	Operating Expenses			
1.	Salaries and Wages			
	a. Direct Patient Care	363,600	380,000	380,000
	b. Non-Patient Care			
2.	Physician's Salaries and Wages			
3.	Supplies	82,300	74,300	82,900
4.	Rent			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates			
5.	Management Fees:			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates			
6.	Other Operating Expenses			
	Total Operating Expenses	$ 445,900	$ 454,300	$462,900
E.	**Earnings Before Interest, Taxes and Depreciation**	$ 147,730	$ 189,846	$ 83,863
F.	Non-Operating Expenses			
1.	Taxes	$	$	$
2.	Depreciation	14,100	17,200	15,800
3.	Interest			
4.	Other Non-Operating Expenses	9,400	13,200	15,400
	Total Non-Operating Expenses	$ 23,500	$ 30,400	$ 31,200
NET INCOME (LOSS)		$ 124,230	$ 159,446	$52,663

Chart Continues Onto Next Page

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NET INCOME (LOSS)		$ 124,230	$ 159,446	$ 52,663
G.	Other Deductions			
1.	Annual Principal Debt Repayment	$	$	$
2.	Annual Capital Expenditure			
	Total Other Deductions	$ 0	$ 0	$ 0
	NET BALANCE	$ 124,230	$ 159,446	$ 52,663
	DEPRECIATION	$ 14,100	$ 17,200	$ 15,800
	FREE CASH FLOW (Net Balance + Depreciation)	$ 138,330	$ 176,646	$ 68,463

X Total Facility

☐ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

	OTHER EXPENSES CATEGORIES	**Year 2014**	**Year 2015**	***Year 2016***
1.	Professional Services Contract	$ 0	$ 0	$ 0
2.	Contract Labor	0	0	0
3.	Imaging Interpretation Fees	0	0	0
4.				
5.				
6.				
7.				
	Total Other Expenses	**$ 0**	**$ 0**	**$ 0**

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X Total Facility
☐ Project Only

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 2018	Year 2019
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits)	1000 Cases	1000 Cases
B.	Revenue from Services to Patients		
1.	Inpatient Services		
2.	Outpatient Services	2,000,000	2,000,000
3.	Emergency Services		
4.	Other Operating Revenue (Specify)_____		
	Gross Operating Revenue	**$ 2,000,000**	**$ 2,000,000**
C	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$ 900,000	$ 900,000
2.	Provision for Charity Care		
3.	Provisions for Bad Debt		
	Total Deductions	$900,000	$ 900,000
NET OPERATING REVENUE		$1,100,000	$1,100,000
D.	Operating Expenses		
1.	Salaries and Wages		
	a. Direct Patient Care	650,000	650,000
	b. Non-Patient Care		
2.	Physician's Salaries and Wages		
3.	Supplies	110,000	110,0000
4.	Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates		
5.	Management Fees:		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates		
	c. Other Operating Expenses		
	Total Operating Expenses	$ 760,000	$ 760,000
E.	**Earnings Before Interest, Taxes and Depreciation**	$ 340,000	$ 340,000
F.	Non-Operating Expenses		
1.	Taxes	$	$
2.	Depreciation	18,000	18,000
3.	Interest		
4.	Other Non-Operating Expenses	15,000	15,000
	Total Non-Operating Expenses	$ 33,000	$ 33,000
	NET INCOME (LOSS)	$ 307,000	$ 307,000

Chart Continues Onto Next Page

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NET INCOME (LOSS)		$ 307,000	$ 307,000
G.	Other Deductions		
1.	Estimated Annual Principal Debt Repayment	$ 0	$ 0
2.	Annual Capital Expenditure	0	0
	Total Other Deductions	$ 0	$ 0
	NET BALANCE	$ 307,000	$ 307,000
	DEPRECIATION	$ 18,000	$ 18,000
	FREE CASH FLOW (Net Balance + Depreciation)	$ 325,000	$ 325,000

X Total Facility

☐ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

	OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1.	Professional Services Contract	$	$
2.	Contract Labor		
3.	Imaging Interpretation Fees		
4.			
5.			
6.			
7.			
	Total Other Expenses	**$ 0**	**$ 0**

DeLozier Surgery Center, LLC
Income Statement
October 31, 2017
Year to Date

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Total Revenue	$	727,403
Operating Expenses		
Salaries & Wages	$	236,706
CC Discount	$	10,319
Cylinder Gas Expense	$	2,454
Lab & Testing	$	5,518
Implant Expense	$	123,270
Pharmaceuticals	$	9,739
Laundry Expense	$	9,111
Anesthesia Fees	$	93,983
Maintenance & Repairs	$	3,958
Taxes & Licenses	$	1,805
Total Operating Expenses	$	496,863
Net Income	$	230,540

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AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Williamson

NAME OF FACILITY: DeLozier Surgery Center

I, R BRIAN WHITE, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 28th day of November, 2017, witness my hand at office in the County of Williamson State of Tennessee.

NOTARY PUBLIC

My commission expires OCT. 12, 2019.

BRICE S. JONES
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY
MY COMMISSION EXPIRES OCT 12, 2019

HF-0043

Revised 7/02


GRACE S. JONES
STATE
OF
PENNSYLVANIA
NOTARY
PUBLIC
WILLIAMSON COUNTY